I: State Information

State Information

Plan Year

Start Year:
2011

End Year:
2013

State DUNS Number

Number
780871430

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name
Missouri Department of Mental Health

Organizational Unit
Division of Alcohol and Drug Abuse

Mailing Address
PO Box 687

City
Jefferson City

Zip Code
65102

II. Contact Person for the Grantee of the Block Grant

First Name
Mark

Last Name
Stringer

Agency Name
Missouri Department of Mental Health, Division of Alcohol and Drug Abuse

Mailing Address
1706 E Elm St

City
Jefferson City

Zip Code
65102-0687

Telephone
573-751-9499

Fax
573-751-7814

Email Address
mark.stringer@dmh.mo.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
7/1/2009

To
6/30/2010

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date
10/3/2011 5:07:03 PM

Revision Date
2/24/2012 10:45:36 AM

V. Contact Person Responsible for Application Submission

First Name
Mark

Last Name
Stringer

Telephone
573-751-9499

Fax
573-751-7814

Email Address
mark.stringer@dmh.mo.gov

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Keith Schafer
Title	Department Director
Organization	Missouri Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Keith Schafer
Title	Department Director
Organization	Missouri Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. FORMULA GRANTS TO STATES, SECTION 1921

II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922

III. INTRAVENOUS DRUG ABUSE, SECTION 1923

IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927

VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928

IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929

X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930

XI. Restrictions on Expenditure of Grant, Section 1931

XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

XIV. Requirement of Reports and Audits by States, Section 1942

XV. ADDITIONAL REQUIREMENTS, SECTION 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Missouri will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name	Keith Schafer
Title	Department Director
Organization	Missouri Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

Step 1: Assess the strengths and needs of the service system to address the specific populations

In Missouri, the Department of Mental Health (DMH) is the agency responsible for developing and implementing a comprehensive response to address behavioral health issues in the state. DMH is organized into three divisions including the Division of Alcohol and Drug Abuse (ADA), the Division of Comprehensive Psychiatric Services (CPS), and the Division of Developmental Disabilities. In addition, the Office of the Director houses the Office of Comprehensive Child Mental Health, the Office of Disaster Readiness, and the Office of Deaf and Multicultural Services. In order to maximize resources and to provide a coordinated approach to behavioral health, the divisions of ADA and CPS have been integrating administrative functions and have common leadership.

At the department level, the director is appointed by the Mental Health Commission, which is composed of seven members who are appointed to four-year terms by the governor with confirmation by the senate. The commissioners serve as principle policy advisors to the department director. The Commission, by law, must include an advocate of community mental health services, a physician who is an expert in the treatment of mental illness, a physician concerned with developmental disabilities, a member with business expertise, an advocate of substance abuse treatment, a citizen who represents the interests of consumers of psychiatric services, and a citizen who represents the interests of consumers of developmental disabilities services.

At the division level, ADA oversees a statewide network of publicly-funded substance abuse prevention, treatment, and recovery support providers. The Division of CPS is responsible for assuring the availability of prevention, treatment, and rehabilitation services for individuals and families requiring public mental health services. Each division has a State Advisory Council (SAC) that serves as an advisory body on policy, prevention, and treatment programming. Over the past year, administrative functions of ADA and CPS have been combined. In addition, the two SAC's have conducted joint subcommittee meetings to develop recommendations for integration of the two councils.

Within ADA, the Division Director, who also serves as Division Director to CPS, is responsible for leading and managing ADA/CPS; directing policy and strategic plans for ADA/CPS; coordinating with other state officials; and representing ADA/CPS in discussions, negotiations and partnerships with other state and federal organizations. The ADA/CPS Director of Administration oversees the fiscal, research, and quality improvement functions. The ADA Director of Community Programs assists in developing and implementing policy and strategic plans for ADA, and oversees utilization review, certification, the substance abuse traffic offenders program, and the Access to Recovery III program. The Director of Community Programs also works in

partnership with key stakeholders, to include other state departments, to improve addiction services in the state. The ADA Prevention Director oversees ADA prevention, mental health promotion, and public communications. The ADA Prevention Director is also project coordinator for Missouri's Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant and works with the Missouri Institute of Mental Health on the development of policies and procedures for that project. The ADA Prevention Director and the ADA Research Coordinator are co-managers for the FDA tobacco enforcement contract and the State Epidemiology Outcomes Workgroup (SEOW) contract. The ADA Research Coordinator is also the DASIS/TEDS manager and the Synar Coordinator.

The division of ADA contracts directly with service providers and does not have administrative intermediaries. Individuals in need of services are not restricted by catchment areas. Missourians may access substance abuse treatment services anywhere in the state regardless of their county of residence.

As of the beginning of FY 2012, ADA was contracting with 91 agencies statewide to provide a continuum of care. Seven treatment agencies provide treatment services funded through the federal Access to Recovery III program. Seven agencies provide specialized services for adolescents. Three contracted agencies and one state-operated agency offer Opioid treatment programs. Eleven agencies provide specialized women's programs. Twenty-five agencies provide general adult treatment programs with three of these providing specialized services for Department of Corrections supervised offenders returning to the community. All treatment contracts also include early intervention services, co-occurring counseling, and deaf and language interpretation services, to be used as needed. All adult treatment contracts provide for medication therapy as clinically appropriate. Thirteen agencies that contract with ADA for substance abuse treatment also contract with CPS for mental health services. ADA, through the support of the federal ATR III grant, also makes available recovery support services through a network of 34 credentialed recovery support providers in central, western, and southern portions of the state. The Division of ADA contracts with two agencies as a statewide resource centers (one of these targets the deaf community), 12 agencies providing primary prevention, and 15 agencies that offer targeted prevention.

The Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program was developed by ADA and is the only substance abuse treatment program that is Medicaid reimbursable. CSTAR offers a flexible combination of clinical and supportive services, to include temporary living arrangements when appropriate, that vary in duration and intensity depending on the needs of the consumer. Available services include assessment; individual and group counseling; group education; community support; residential or housing support, as appropriate; trauma-specific individual counseling and group education; individual co-occurring disorders counseling; family therapy;

medications, physician and nursing services to support medication therapy. In addition, families can also participate in individual and group codependency counseling.

Missouri has four types of CSTAR programs: women and children, adolescent, general population, and Opioid. All offer three graduated levels of care that vary in duration and intensity. Persons may enter treatment at any level in accordance with eligibility criteria. All but Opioid programs offer a residential component for individuals needing that kind of structure and support. Consumers can enter the program at any level and move between levels depending on their assessed needs, problem severity and treatment progress.

The Division of ADA is an accrediting body for Opioid Treatment Programs (OTP). The OTP's provide outpatient services to individuals who are addicted to opiates. These services include dispensing of clinically appropriate medications, primarily methadone, to prevent withdrawal and/or relapse. In Missouri, eleven agencies are certified as OTP's. An ADA Program Specialist is the designated State Opioid Treatment Authority (SOTA) and provides oversight and clinical assistance to the OTP's to ensure that treatment is consistent with best practices and federal requirements.

Specialized CSTAR programs are offered for women and their children with programming that is tailored to this population. Pregnant women and women with children in their care are prioritized populations. The full array of services is available and is individualized to meet the consumer's unique needs. In addition, daycare is provided to ensure childcare is not an obstacle to treatment participation.

Adolescent CSTAR programs offer a full continuum of services provided by specially trained staff to consumers 12 to 17 years of age. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Consumers in residential settings are offered academic support services to minimize disruptions in their education.

The Primary Recovery Plus (PR+) program, modeled after the CSTAR program, also provides a full continuum of services within multiple levels of care. Historically, detoxification services were only accessed through PR+ providers but available to any Missourian in need of such services. During FY 2011, ADA submitted a request to the Centers for Medicare and Medicaid Services (CMS) through Missouri's Medicaid program, MO Healthnet, to include modified medical detoxification as a Medicaid reimbursable service in the CSTAR adult programs. That request received approval and will be implemented in fall 2011. Over the past two years, ADA has encouraged the conversion of PR+ contracts to CSTAR contracts in order to maximize resources. Since summer 2009, 22 PR+ contracts have been converted to CSTAR with 5 PR+ programs remaining.

The Division of ADA also oversees the Substance Abuse Traffic Offender Program (SATOP), which is a statewide system of comprehensive, accessible, community-based education and treatment programs designed for individuals arrested for alcohol- or drug-related traffic offenses. The mission of SATOP is to: (A) inform and educate these offenders as to the hazards and consequences of impaired driving; (B) promote safe and responsible decision making regarding driving; (C) motivate for personal change and growth; and (D) contribute to public health and safety in Missouri. ADA certifies and monitors the SATOP programs which offer varying levels of care. The Offender Education Program and Adolescent Diversion Education Program is a10-hour education course designed to assist low-risk, first-time offenders in understanding the choices they made that led to impairment and arrest. The Weekend Intervention Program is designed for second-time offenders or high-risk, first-time offenders and provides 20 hours of education and intervention during a 48-hour weekend of structured activities. The Clinical Intervention Program and Youth Clinical Intervention Program are outpatient treatment programs, 50 hours and 25 hours of care respectively, designed for third-time offenders or high-risk first- or second-time offenders. The Serious and Repeat Offender Program is a long-term, comprehensive outpatient treatment program designed for individuals considered serious or chronic offenders including those participating in DWI courts. The SATOP program serves approximately 30,000 Missourians annually.

The Division of ADA has a SAMHSA-funded Access to Recovery III grant. Hallmarks of this program include 1) a voucher driven funding system ensuring consumer choice, 2) involvement of faith-based, community-based, and grassroots organizations in providing services, and 3) recovery support services to initiate or sustain recovery from substance abuse. Some of the available recovery support services are housing, transportation, recovery coaching, family engagement, and work preparation. The program also fosters person-centered recovery planning which is based on an assessment and is the result of equal collaboration between the consumer and the service provider(s). Priority populations for the ATR III program include: 1) veterans, including National Guard service members returning from Iraq and Afghanistan, 2) Offenders re-entering the community, and 3) treatment court participants. Recovery-oriented systems of care (ROSC) have been established in Kansas City and west central, southwest, and southeast areas of the state. Missouri has strong representation from faith-based agencies in its ROSC's. Of the 34 agencies that provide recovery support services, 25 of these are faith-based organizations.

The Division of ADA partners with the Missouri Institute for Mental Health (MIMH) at the University of Missouri-St Louis to implement the SAMHSA-funded Screening Brief Intervention and Referral to Treatment (SBIRT) program. Under the SBIRT program, a computer-based screening tool is used by trained health coaches in emergency rooms

and family medicine clinics to screen for risky substance use behaviors. SBIRT has been implemented in Springfield, Columbia, and St. Louis, Missouri.

DMH partners with other state agencies to ensure that quality services are delivered in a coordinated manner and resources are optimized. DMH works closely with the Department of Social Services (DSS), which is the Medicaid authority for the state. The Divisions of ADA and CPS coordinate with DSS for services and programs provided to Medicaid eligible individuals and work on initiatives including a protocol for referring pregnant women, healthcare homes, and disease management. For healthcare homes, Missouri has submitted a Medicaid State Plan Amendment to CMS for Community Mental Health Center Health Care Homes and is awaiting approval. The Disease Management project is a two-year project targeting high cost Medicaid clients who have chronic medical conditions along with a co-occurring mental health disorder. Many also have substance use disorders. For those individuals that qualify for the Disease Management program, DSS is making funding available to pay for Community Psychiatric Rehabilitation (CPR) and CSTAR services.

In addition, the Division of ADA partners with the Department of Corrections (DOC) for the implementation of a referral process, as well as monitoring and evaluation of programs and services provided to DOC offenders under community supervision. A Memorandum of Understanding with the DOC delineates the terms of this collaborative relationship. The community-based programs for offenders that are managed by ADA include outpatient services throughout the state, Alt-Care and Free and Clean programs in St. Louis and Kansas City, and a Partnership for Community Restoration program in St. Louis. The Alternative Care (Alt Care) program is a women and children's program designed for female offenders being released from the correctional institutions and those under probationary supervision.

The Department of DMH subcontracts with the Department of Public Safety for enforcement of the Family Smoking Prevention and Tobacco Control Act and partners with the Department of Elementary and Secondary Education for administration of the biennial Missouri Student Survey. The Division of ADA is represented on interagency groups including the Council for Adolescent School Health; the Missouri Coordinated School Health Coalition; Comprehensive System Management Team (for state agencies providing services to children); the Missouri HIV/STD Prevention Community Planning Group; Show Me Response (disaster & emergency coordination); Missouri Reentry Process Steering Team; MO HealthNet Managed Care Quality Assurance & Improvement Advisory Group (Medicaid); Alliance to Curb Problem Gambling; Midwest Consortium on Problem Gambling and Substance Abuse Committee; Mental Health and Aging Workgroup; Smoking Cessation Planning Workgroup; the Impaired Driving Subcommittee, Coalition for Roadway Safety; and the Drug Court Coordinating Commission.

As part of its prevention network, the Division of ADA contracts with 11 Regional Support Centers (RSCs) for ongoing technical assistance to 167 community coalitions comprised of a diverse representation of the community. The community coalitions are present in most of Missouri's 114 counties plus the city of St Louis and involve approximately 1,670 local volunteers. The ongoing technical assistance is provided to support capacity building at the local level through community needs assessments, resource identification, development of community plans to address the identified needs, implementation of the plans, and the evaluation of data for outcomes. The technical assistance provided by the RSCs increases the coalition's information and skills necessary to prevent substance abuse.

Missouri's higher education substance abuse consortium, Partners in Prevention (PIP), has a membership of 13 public universities and 7 private universities. PIP uses the Strategic Prevention Framework to create positive change on their college campuses. Full-time enrollment for PIP schools is over 155,000 students. PIP also administers the Missouri College Student Health Behavior Survey (MCHBS) at the 20 universities. Over 6,500 students participate in the survey designed to assist in determining the needs of the campuses and obtain aggregate statewide data. PIP also provides targeted prevention for students at increased risk for underage and binge drinking. PIP administers Community Trials, Brief Alcohol Screening and Intervention for College Students (BASICS), and SMART to almost 9,000 students annually.

The eleven Regional Support Centers (RSC), the Statewide Training and Resource Center (STRC), the University of Missouri, and 167 local coalitions implement population-based programs and activities. The broadcast media are utilized to reach about 4 million individuals aged 5-64 years. The 167 volunteer coalitions recognizes national prevention programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3D Month, and Alcohol Awareness Month.

ADA uses the Statewide Training and Resource Center (STRC) to provide information, technical assistance, and training to the substance abuse prevention workforce who includes ADA and the contractual prevention staff. The STRC, a member of Community Anti-Drug Coalitions of America (CADCA), represents Missouri at national conferences. Under the direction of ADA, the STRC administers training, development and consultant resources to the 167 Missouri registered coalitions.

ADA supports the Missouri Youth/Adult Alliance (MYAA), a statewide coalition that provides resource materials and educational opportunities to local community efforts focused on addressing underage drinking. MYAA addresses the topics of environmental and social policy change during the annual Speak Hard workshop for youth in Jefferson City. MYAA also distributes brochures, pamphlets, and other materials on underage drinking.

ADA supports the St. Louis Arc in delivering Fetal Alcohol Syndrome (FAS) information, education and promoting awareness to youth aged 12-21 in St Louis schools. St. Louis Arc distributes information and promotional materials through health fairs, conference, and town hall meetings.

ADA's school-based prevention programming supports implementation of prevention curricula of proven effectiveness at reducing alcohol and other drug use and reducing incidences of violent behavior among children in grades kindergarten through 12. The School-based Prevention Intervention and Resources Initiative (SPIRIT) program is in five school districts: Knox County, Carthage, Hickman Mills, New Madrid, and Ritenour. The school districts participating in SPIRIT were identified as high-risk districts based on the number of youth for each district, the number of referrals to juvenile authorities, school drop-out rates, and the number of students receiving reduced or free lunches. The programs include Peace Builders, Second Step, Project Towards No Drug Abuse, Life Skills and Too Good For Drugs. During 2010, SPIRIT has served over 9,400 students in grades K-9.

Targeted prevention services are being provided through eight community-based agencies located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern Missouri known as the Missouri Bootheel. The subgroups targeted by these community-based agencies include youth who are experiencing academic failure located in communities identified as low income. The evidence-based programs and strategies implemented by these agencies include Creating Lasting Connections, Creating Lasting Family Connections (age 9-17), Passport to the Future: Urban Rhythms (age 5-18), Too Good For Drugs (age 11-14), after school mentoring emphasizing bullying prevention (age 12-14), Life Skills (age 12-14), faith-based programs specializing in youth substance abuse prevention (age 12-18), Promoting Responsibility through Education and Preparation (PREP) program (age 9-11), Lincoln University Youth Development Kid's Beat (age 6-18), All Stars (age 11-14), and How to Cope (age 18+). Approximately 62,000 Missourians are served annually.

Targeted prevention services are provided through the Missouri Alliance of Boys and Girls Clubs, consisting of 13 Boys and Girls Club sites located throughout the state. The target subgroup for the Missouri Alliance of Boys and Girls Clubs is youth who may be academically failing and low-income. The 13 Boys and Girls Club sites provide SMART Moves and MethSMART to over 60,000 youth ages 5-18 annually.

ADA supports targeted prevention programming for the deaf community through the Leadership Education and Advocacy for the Deaf (L.E.A.D.), the statewide provider for Deaf and Hard of Hearing. L.E.A.D. targets the subgroup of Deaf and Hard of Hearing youth in Missouri. L.E.A.D. organizes The Teen Institute for the Deaf for over 1,000

youth ages 12-17. The Teen Institute provides training in alcohol and other drug abuse prevention strategies and skills.

Contracted treatment providers are required to include culturally competent programming. In addition, language translation services must be provided as needed for consumers who speak a primary language other than English. One of ADA's contracted providers (Preferred Family Healthcare, Inc.) has a SAMHSA-funded Targeted Capacity HIV/AIDS grant to target services including substance abuse treatment, HIV/AIDS testing and counseling, and housing supports for at-risk groups including women, young adults, and injection drug users including men who have sex with men. Another ADA contracted treatment provider (Queen of Peace Center) also has a Targeted Capacity HIV/AIDS grant to target services for at-risk substance abusing African American women residing in the City of St. Louis. Several contracted treatment providers have SAMHSA-funded grants to expand substance abuse treatment and recovery supports to homeless individuals. These agencies include: Community Alternatives, Inc.; Swope Health Services; Burrell Behavioral Health; and Phoenix Programs, Inc. ADA contracts with several agencies that provide outreach and/or specialized programming for the African-American populations. These agencies include B.A.S.I.C., Southeast Missouri Behavioral Healthcare Center, and Gibson Recovery Center. Several of the ATR III recovery support providers target services and programs for women. These agencies include Veronica's Voice (works with women in the commercial sex industry), Mending Hearts (works with female offenders re-entering the community), Recycling Grace Women's Center, Inc. (works with women in recovery from addictions and trauma), and Sheffield Place (works with homeless mothers and their children). One of ADA's contracted providers (Sigma House) provides early intervention services for adolescent females who are just beginning to have issues with the juvenile justice system. This program (EPIC House) is done in cooperation with the Greene county Juvenile Office and is supported by a SAMHSA Reclaiming Futures grant. ADA certifies two outpatient programs (The Guadalupe Center and Mattie Rhodes Center) that provide specialized programs for the Hispanic and Latino communities. ATR III staff continues to work to engage recovery support providers who provide specialized services and programming for the Hispanic and Native American communities.

ADA contracts with prevention providers who provide programming targeting at-risk youth including minority youth. Friends with a Better Plan serves primarily African-American youth ages 13-18 in five secondary schools in St. Louis. Lincoln University-Kid's Beat serves youth in economically depressed areas including the southeast Bootheel counties and provides outreach to disadvantaged, African-American youth. Discovering Options provides substance abuse prevention afterschool and mentoring programming for children living in extremely impoverished areas in St. Louis – many of

whom are African-American. ADA certifies a school-based program (De LaSalle) in Kansas City that provides substance abuse assessment and treatment for high-risk, underserved youth including minority youth.

A major challenge faced by ADA treatment and prevention programs is adjusting to reduced funding levels from both the state and federal levels. Less funding is available for treatment services due to reductions in funding of federal programs such as the Access to Recovery program and the Substance Abuse Prevention and Treatment Block Grant and reductions in state general revenue. In addition, prevention has realized the loss of federal Safe and Drug-Free Schools funding as well as the ending of the Strategic Prevention Framework State Incentive Grant. Regardless, the Division remains committed to providing Missourians with opportunities to achieve recovery and live full, healthy lives through quality treatment and prevention services and programming.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Step 2: Identify the unmet service needs and critical gaps within the current system

The Division of Alcohol and Drug Abuse (ADA) planning utilizes prevalence data, substance abuse indicators, treatment admissions data, population estimates, needs assessments, and outcomes data. Prevalence data, which encompasses alcohol and drug use, abuse, and dependence, is derived from several national and state surveys. ADA acquires state and sub-state estimates from the National Survey on Drug Use and Health (NSDUH), state estimates from the Youth Risk Behavior Survey (YRBS), state estimates from the Behavioral Risk Factor Survey (BRFS), state and county-level data from the Missouri Student Survey (MSS), and state data collected from 13 university campuses and 6 private campuses using the Missouri College Health Behavior Survey (MCHBS). ADA annually updates prevalence estimates using the most current survey data.

ADA collects an array of substance abuse indicator data, mostly from other state agencies. The indicators include a variety of alcohol and drug related events including traffic crashes, fatalities, injuries, and DUI arrests; HIV/AIDS cases; hospital and emergency room admissions; impaired births; induced deaths; adult and juvenile arrests; school discipline incidents; out-of-home juvenile placements, methamphetamine lab confiscations; probation, parole, and prison admissions; and drug court enrollments. In addition, ADA also collects other indicator data including school dropouts, juvenile status offenses, domestic violence, violent and property crime indices, and unemployment. ADA annually assembles the indicators into geographic profiles for Missouri's 114 counties plus the city of St. Louis, the ADA planning regions, service areas, and the state.

Substance abuse and mental health treatment admissions data are retrieved from the DMH Customer Information, Management, Outcomes, and Reporting (CIMOR) system, based on each consumer's county of residence. Aggregate data include basic demographic, substance abuse problem, diagnostic information, and treatment services information, and are annually assembled by fiscal year into geographic profiles for the counties, planning regions, service areas, and the state.

The prevalence estimates, substance abuse indicators, and treatment admissions data are compiled for the annual Status Report on Missouri's Substance Abuse and Mental Health Problems (formerly the Status Report on Missouri's Alcohol and Drug Problems), and posted on the ADA public website at: http://dmh.mo.gov/ada/rpts/status.htm. The report provides a narrative epidemiologic profile of the impact of substance abuse on the state and the challenges substance abuse issues present to the state.

Aside from the development of quantitative data, sub-state planning involves input on program needs from advisory councils, staff, service providers, and other informed individuals. The SAC is a statutory body comprised of up to 25 members appointed by the ADA director to three-year overlapping terms. Current SAC membership includes consumer advocacy groups, service providers, and representatives from other state and local agencies. Among other duties, the SAC collaborates with ADA in developing a state plan on alcohol and drug abuse; promotes programs to reduce the debilitating effects of alcohol and other drugs; and disseminates information on substance abuse prevention, treatment, and rehabilitation. Treatment and prevention subcommittees of the SAC have active roles in providing information, resources, and recommendations.

ADA has three district offices and two satellite offices staffed by district administrators and treatment coordinators, who provide referrals to ADA programs, monitor service providers, and provide technical assistance to service providers. The ADA executive management team includes the ADA director and deputy director, the district administrators, the prevention director, the clinical treatment director, the Access To Recovery project director, the director of operations, the Substance Abuse Traffic Offenders Program (SATOP) director, and the ADA research director. The ADA executive staff uses data from needs assessments, analyses prepared by the ADA research staff and fiscal staff, and recommendations from the SAC to formulate the ADA annual budget, reallocations, and budget cuts when required. The use of these multiple sources of information helps to ensure that ADA expends its SAPT Block Grant funds in communities and for populations with the greatest need.

ADA facilitates performance monitoring using the prevention and treatment National Outcomes Measures (NOMs); the prevention Minimum Data Set (MDS); and the Treatment Episode Data Set (TEDS). ADA provides funding to administer the biennial MSS survey to secondary school students. ADA also provides funding for the Partners in Prevention program, which conducts the MCHBS for college students. These data sources provide important information to monitor sub-state prevalence rates for Missouri adolescents and young adults.

In 2010, Missouri was awarded a SAMHSA State Epidemiology Outcomes Workgroup (SEOW) contract. The state used this funding to revitalize its SEOW workgroup after the state's Strategic Prevention Framework State Incentive Grant ended. The mission of Missouri's SEOW is:

- To create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and its communities;

- To inform and guide behavioral health prevention policy, program development and evaluation in the State; and
- To disseminate information to State and community agencies, to targeted decision-makers, and to the public.

Missouri's SEOW is chaired by a Research Assistant Professor at the Missouri Institute for Mental Health – University of Missouri, St. Louis. The SEOW project director is the ADA Prevention Director and National Prevention Network (NPN) representative. The SEOW Data Manager is the ADA Research Coordinator. Membership includes representation from mental health, social services, public safety, health, education, and the judicial system.

Name	SEW Position	Title	Agency
Susan Depue	chairperson	Research Assistant Professor	Missouri Institute for Mental Health
Angie Stuckenschneider	member	Prevention Director	Missouri Department of Mental Health Division of Alcohol and Drug Abuse
Christie Lundy	member	Research Coordinator	Missouri Department of Mental Health Division of Alcohol and Drug Abuse
Clive Woodward	member	Director of Quality Improvement	Missouri Department of Mental Health Division of Comprehensive Psychiatric Services
Rebecca Kniest	member	Research Analyst	Missouri Department of Social Services Research & Evaluation
Ron Beck	member	Director	Missouri State Highway Patrol Statistical Analysis Center
Shumei Yun	member	State Epidemiologist	Missouri Department of Health and Senior Services Division of Community and Public Health
Anne Janku	member	Research Manager	Office of State Courts Administrator
Liz Sale	member	Research Associate Professor	Missouri Institute for Mental Health
Bill Elder	member	Director	Office of Social and Economic Data Analysis
Michael McBride	member	Underage Drinking Prevention Coordinator	Partners in Prevention
Mary Pearce	member	SES Supervisor	Missouri Department Of Elementary And Secondary Education Office of Data System Management

Name	SEW Position	Title	Agency
Supporting Staff			
Randy Smith	data support	Project Specialist	Missouri Department of Mental Health Division of Alcohol and Drug Abuse

Under the SEOW program, Missouri had developed epidemiology profiles for each of the 114 counties plus the city of St. Louis and for the state as a whole. The group continues to assess data gaps, enhance capacity to use behavioral health data, promote data driven decision-making, increase dissemination of data and analyses, promote common data standards, and increase data collaborations.

Total Treatment Need

Table 1 Total Unmet Substance Abuse Treatment Need.

Substate Planning Area	2009 Population Age 12+	Estimated Need	Estimated Received Treatment	Estimated Unmet Need	Penetration Gap
Northwest	1,246,860	102,224	13,931	88,293	86.37%
Central	664,609	57,154	9,503	47,651	83.37%
Eastern	1,779,880	160,361	16,595	143,766	89.65%
Southwest	765,748	68,457	9,857	58,600	85.60%
Southeast	582,501	50,805	9,971	40,834	80.37%
State Total	5,039,598	439,000	59,857	379,143	86.37%

Statewide estimates for substance abuse treatment need are obtained from the National Household Survey (NSDUH) (2008-2009) (SAMHSA, 2011a). The total is allocated among the substate planning areas in accordance with substate estimates obtained from the 2006-2008 NSDUH (SAMHSA, 2010). The estimate for received treatment was obtained by weighting the number of individuals served in the publicly-funded system by the total number estimated to receive treatment obtained to the total number served in the publicly-funded system from the National Survey of Substance Abuse Treatment Services (SAMHSA, 2011b). This is done in an attempt to account for excess persons who would receive treatment outside of the publicly-funded system. The difference between estimated need and estimated received numbers yields estimated need but did not receive treatment. Penetration gap is that proportion of estimated need that did not received treatment. County-level population of persons age 12 or older was obtained from the Missouri Census Data Center and aggregated to the substate areas (Missouri Census Data Center, 2011).

Healthcare Homes

Individuals with co-occurring mental illness and substance abuse disorders are at greater risk for relapse and tend to have poorer outcomes in comparison to individuals with only a substance abuse disorder (Compton, W.M., Cottler, L.B., Behn-Abdallah, A., & Spitnagel, E.L., 2003; Hser, Y.I., Evans, E., Teruva, C., Huang, D., & Anglin, M.D., 2007). In addition, expenditures for co-occurring individuals on Medicaid tend to be higher because of not only the substance abuse and mental illness disorders but also accompanying physical disorders (Clark, R.E., Samnaliev, M., & McGovern, M.P., 2009). The Missouri Department of Mental Health (DMH) is proposing a Healthcare Home model for its Community Mental Health Centers (CMHC). Under this model, individuals with co-occurring disorders served by the CMHC's will have monitoring of their health status; coordination of their care including their physical health needs; individualized care planning; and promotion of self-management. The Healthcare Homes Implementation plan calls for the auto-enrollment of 365 adults and 34 youth who are 1) Medicaid eligible, 2) have had Medicaid expenditures of at least $10,000 in the past year, 3) are out of Medicaid spenddown, and 4) are still being served by the CMHC.

Behavioral Health Data

ADA collects an array of substance abuse indicator data, mostly from other state agencies. The indicators include a variety of alcohol and drug related events including traffic crashes, fatalities, injuries, and DUI arrests; HIV/AIDS cases; hospital and emergency room admissions; impaired births; induced deaths; adult and juvenile arrests; school discipline incidents; out-of-home juvenile placements, methamphetamine lab confiscations; probation, parole, and prison admissions; and drug court enrollments. In addition, ADA also collects other indicator data including school dropouts, juvenile status offenses, domestic violence, violent and property crime indices, and unemployment. ADA annually assembles the indicators into geographic profiles for Missouri's 114 counties plus the city of St. Louis, the ADA planning regions, service areas, and the state.

The prevalence estimates, substance abuse indicators, and treatment admissions data are compiled for the annual Status Report on Missouri's Substance Abuse and Mental Health Problems (formerly the Status Report on Missouri's Alcohol and Drug Problems), and posted on the ADA public website at: http://dmh.mo.gov/ada/rpts/status.htm. This is a static report. The state seeks to develop a web-based analytic tool similar to what has been developed in Arizona (http://www.bach-harrison.com/arizonadataproject), Minnesota (http://www.sumn.org/), and Kentucky (http://sig.reachoflouisville.com/). This tool is needed to improve access and user interface with data and data products; to

increase dissemination of data and analyses; and enhance the overall capacity to use behavioral health data.

Chronic Drunk Driving

Table 2 Chronic DWI Offenders as of July 2, 2011.

Substate Planning Area	DWI Offenders with 4+ DWI's with the Most Recent DWI Occurring in the Past Year	FY 2011 Number Served in Serious and Repeat Offender Program	Unmet Need	Penetration Gap
Central	205	34	171	83.41%
Eastern	404	72	332	82.18%
Northwest	444	30	414	93.24%
Southeast	248	23	225	90.73%
Southwest	283	222	61	21.55%
Total	1,584	381	1,203	75.95%

In Missouri, the Department of Revenue (DOR) is responsible for collecting DWI arrest data from enforcement agencies and is authorized to take administrative action if an individual's blood alcohol content is over the legal limit or if the driver refuses to submit to an alcohol and/or drug test when requested by a law enforcement officer. The drivers license abstract file is obtained from DOR on a quarterly basis. Resident addresses are geocoded and the corresponding substate planning area is determined through geographic information system (GIS) analysis. The number of non-deceased individuals who had four or more DWI's with the most recent DWI occurring in the past year was determined. The number of individuals who received treatment in the Serious and Repeat Offender Program (SROP) was obtained from the DMH billing system. Estimated unmet need is the difference between number of chronic offenders and the number served in the SROP program. Penetration gap is that proportion of chronic offenders with recent DWI who did not received long-term treatment. The SROP program was first piloted in Southwest region which is the reason for the relatively high number served in that region.

Department of Corrections Community Supervised Offenders

Table 3 Unmet Treatment Need for Probation and Parole.

Substate Planning Area	FY 2011 Probation and Parole Population	Probation and Parole Need	Probation and Parole FY 2011 Served	Estimated Unmet Need	Penetration Gap
Northwest	23,444	8,205	4,219	3,986	48.58%
Central	14,672	5,135	3,592	1,543	30.05%
Eastern	36,606	12,812	5,278	7,534	58.80%
Southwest	13,735	4,807	3,602	1,205	25.07%
Southeast	18,726	6,554	4,410	2,144	32.71%
State Total	107,183	37,514	21,101	16,412	43.75%

The number of individuals on parole or probation for FY 2011 was obtained from the Missouri Department of Corrections (DOC). Estimated need for substance abuse treatment was determined from the DOC Substance Abuse Classification Assessment. Most individuals receive an assessment when they enter prison and when they start community supervision. An estimated 35 percent of those offenders on community supervision need substance abuse treatment (based on a SACA score of 4 or 5). This estimate agrees well with estimated of need among those on parole or probation nationwide (35%) – from analysis of the 2009 NSDUH (SAMHSA, 2009). Number served in the publicly-funded system for FY11 was obtained from the Missouri Department of Mental Health billing system. Estimated unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not received treatment.

Tobacco Sales to Minors

Approximately 28 percent of Missouri's high school seniors report smoking in the past 30 days (Missouri Department of Health and Senior Services, 2009). Research has shown that higher merchant compliance with tobacco control laws predicts lower levels of youth smoking (DiFranza, Savageau, & Fletcher, 2009). The Missouri Division of Alcohol and Drug Abuse is the state agency that oversees the state's federal Synar requirements and partners with the Division of Alcohol and Tobacco Control for tobacco control efforts. Federal Synar regulations require all states to maintain a retailer non-compliance rate of no more than 20 percent (42 U.S.C. 300x-26 and 45 C.F.R. 96.130). Since 1996, ADA is charged with overseeing the Synar requirements in Missouri, conducting the annual Synar survey, and implementing tobacco prevention activities as it relates to the sale of tobacco products to minors. A state that fails to comply with the federal Synar requirements is at risk for losing SAPT Block Grant funding.

Recovery Oriented Systems of Care

Research has shown that, for many individuals, recovery coaching, 12-step programs, spirituality, and social and community supports play an important role in maintaining long-term recovery (SAMHSA, 2009a). The state's treatment system does not have the resources to meet the current demand. Waiting lists are the norm for consumers trying to access services. Rural areas of the state, in particular, have a limited array of services as specialized programs and services are more difficult to sustain due to the low population density and transportation issues. While ADA has sought additional state funding to support recovery support services in the past, serious state budget deficits and difficult economic conditions have precluded such funding. ADA has applied for and received SAMHSA-funded Access To Recovery (ATR) I grant which ended in 2007 & ATR II grant which ended in 2010. Under ATR I, ADA implemented a voucher system and created a network of recovery support providers including many faith-based providers. Under ATR II, the state increased focus on the implementation of evidence-based practices and added reentry coordination services to the menu of recovery support services. In 2010, ADA applied for and received the ATR III grant. Under this grant, ADA has implemented a model to focus on local recovery-oriented systems of care and to provide outreach and priority to 1) Veterans and National Guard soldiers, 2) Treatment court participants, and 3) Department of Corrections offenders returning to the community.

Medication Therapy

Medication therapy is the use of medications, in combination with psychosocial counseling, to support treatment and recovery from substance abuse disorders. The Missouri Division of Alcohol and Drug Abuse fully supports the use of evidence-based practices in substance abuse treatment, which includes medication therapy. Missouri now requires the public sector treatment programs to provide medication therapy, consistent with the National Quality Forum recommendations. The National Quality Forum recommendations state that pharmacotherapy should be made available to all adult patients diagnosed with an alcohol or Opioid dependence if no medical contradictions are applicable (National Quality Forum, 2007).

Community Advocacy and Education

Approximately 439,000 Missourians have a substance abuse problem (SAMHSA, 2011a). Alcohol, tobacco, and other drug use is impacted by social acceptability including community laws and norms favorable toward use as well as by availability of the substances. Missouri's 164 community coalitions; the 11 regional support centers; and Missouri's higher education substance abuse consortium, Partnerships in Prevention (PIP) work to change community norms, policy, and substance availability in support of creating healthy, safe communities. The Regional Support Centers, in

collaboration with the community coalitions, develop, implement, and evaluate a comprehensive strategic plan with identified target outcomes based on community needs. Some issues facing Missouri's communities include: 1) methamphetamine laboratories in rural parts of the state, particularly in Southeast and Southwest Missouri; 2) a growing problem with prescription drug misuse; and 3) increased availability and use of heroin in Eastern Missouri. In addition, the statewide use of tobacco products tends to be higher than that for the country as a whole. From January through September 2011, Missouri had 1,574 methamphetamine incident seizures – higher than any other state (Missouri Department of Public Safety, 2011). Approximately 4.5% of Missourians age 12 or older engage in nonmedical use of pain relievers in the past year (SAMHSA, 2011a). In 2009, the rate heroin-related deaths was 7.06 per 100,000 persons for Eastern Region – higher than any other region in the state (Missouri Department of Mental Health, 2011b). Current use of tobacco by Missourians age 12 or older is 32.7 percent – higher than that for the United States (28.02%) (SAMHSA, 2011a).

Quality Improvement

According to NIATx, if an organization wants to serve their customers better, then that organization should focus on ways to improve its processes (NIATx, 2009). ADA seeks to promote continuous quality improvement in substance abuse treatment services provided to Missourians. Originally, ADA implemented the monthly *Change Leaders* conference call with service providers to facilitate the implementation of medication therapy. Recently, the calls have been re-tooled to take a broader perspective on innovative practices to address waiting lists, no-shows, and retention in treatment. Providers participate on a voluntary basis. Providers are encouraged to pick a NIATx aim and to develop a project to address the aim. Providers share their experiences and insight during these monthly calls that are facilitated by two ADA staff from the treatment unit.

Intravenous Drug Users

Table 4 Unmet Treatment Need for IV Drug Users.

Substate Planning Area	2009 Population age 12+	Estimated IVDU Need	IVDU FY 2009 Served	Estimated Unmet Need	Penetration Gap
Northwest	1,246,860	5,984	1,137	4,847	81.00%
Central	664,609	3,190	769	2,421	75.89%
Eastern	1,779,880	11,035	2,238	8,797	79.72%
Southwest	765,748	3,675	1,588	2,087	56.79%
Southeast	582,501	2,796	1,042	1,754	62.73%
State Total	5,039,598	26,680	6,774	19,906	74.61%

In the past, the number of intravenous drug users (IVDU) was estimated as 0.18 percent of the population aged 12 or older from NSDUH national-level data. Based on 1) the number of IV drug users served and the number on wait lists and given that 2) NSDUH excludes some populations with higher rates of drug use such as incarcerated individuals, homeless, hospitalized patients, and college dormitory students, the NSDUH estimate was believed to generate estimates for Missouri that seriously underestimates the number of IV drug users in the state. Research from Brady et al. estimated the prevalence of IV drug users in the U.S. and in 76 metropolitan statistical areas (MSA) (Brady, J.E., Friedman, S.R., Cooper, H.L.F., Flom, P.L., Tempalski, B., & Gostnell, K., 2008). Brady's estimates for IV drug users in the Kansas City and St. Louis MSA's exceeded that generated from the NSDUH data by a factor of 2.7 and 3.4, respectively. Brady's prevalence rate for Kansas City MSA and St. Louis MSA was applied to the populations of Northwest and Eastern regions. The remaining regions was assumed to have a similar rate as that of Northwest region and a corresponding estimate was generated for the remaining regions. The number of IVDU's served by substate region was obtained from the publicly-funded system (Missouri Department of Mental Health, 2011). The estimated number for unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not received treatment. County-level population of persons age 12 or older was obtained from the Missouri Census Data Center and aggregated to the substate areas (Missouri Census Data Center, 2011). Southwest and Southeastern regions have the lowest penetration gaps although they remain of significant size. Methamphetamine IV drug use is prevalence in these area. Increased law enforcement and community efforts over the past decade have increased treatment admissions for IV drug users in southern Missouri. In Eastern region, heroin IV drug use overwhelmingly dominates the injection drug scene. In Northwest region, methamphetamine is the most common followed by heroin and other opiates.

Pregnant Women

Table 5 Unmet Treatment Need for Pregnant Women.

Substate Planning Area	Number of Resident Births	Pregnant Female Need	Estimated Received Treatment	Estimated Unmet Need	Penetration Gap
Northwest	20,744	1,908	276	1,908	83.57%
Central	10,227	940	192	940	76.81%
Eastern	26,991	2,483	398	2,483	81.79%
Southwest	12,033	1,107	198	1,107	79.67%
Southeast	8,853	814	200	814	72.11%
State Total	78,848	7,252	1,266	7,252	80.20%

State level NSDUH data had been requested from SAMHSA for need for treatment for Missouri's pregnant women (February 26, 2010). Even combining years, the precision was too low for estimates for the state to be provided. To estimate the number of pregnant women who need substance abuse treatment, the percent of U.S. pregnant women who needed treatment (8.1%) from NSDUH was applied to the number of resident births which was used as a proxy for number of pregnant females (SAMHSA, 2011b; Missouri Department of Mental Health, 2011c). The estimate for received treatment was obtained by weighting the number of pregnant females served in the publicly-funded system by the total number estimated to receive treatment to the total number served in the publicly-funded system from the National Survey of Substance Abuse Treatment Services (SAMHSA, 2011b). This is done in an attempt to account for excess persons who would receive treatment outside of the publicly-funded system. The number estimated to need but not receive treatment is the difference between the number estimated to need and the number estimated to have received. Penetration gap is that proportion of estimated need that did not received treatment.

Incidence of Communicable Diseases

Table 6 Incidence of HIV and TB per 100,000 persons for 2009.

Substate Planning Area	HIV	TB
Northwest	11.7	1.6
Central	2.7	0.6
Eastern	12.3	1.7
Southwest	3.8	1.0
Southeast	2.9	0.7
State Total	8.5	1.3

The number of new cases of HIV and TB are obtained from the Missouri Department of Health and Senior Services by county and aggregated to the ADA regional level.

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II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:
2011

End Year:
2013

Number	State Priority Title	State Priority Detailed Description
1	Healthcare Homes	The Health Home under the Affordable Care Act is an alternative approach to the delivery of health care services that promises better patient experience and better results than traditional care. The Health Home has many characteristics of the Patient-Centered Medical Home but is customized to meet the specific needs of low-income patients with chronic medical conditions. Missouri is the first state to submit its plan to the Centers for Medicare and Medicaid Services (CMS). Missouri will use this initiative to reduce inpatient hospitalization and emergency room visits, enhance the amount of primary care nurse liaison staffing available at community mental health centers, add primary care physician consultation, and enhance the State's ability to provide transitional care between institutions in the community. Under Missouri's plan, Community Mental Health Centers (CMHC) are eligible to be Healthcare Homes. Most CMHC's have contracts with the Division of Alcohol and Drug Abuse to provide Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs. For an individual to be eligible for enrollment in Missouri's Healthcare Home, he/she must meet one of the following three conditions: 1) have a serious and persistent mental illness, 2) have a mental health condition and a substance abuse disorder, or 3) have a mental health condition or a substance abuse disorder and one other chronic health condition.
2	Behavioral Health Data	Under a contract with the Substance Abuse and Mental Health Services Administration (SAMHSA), the state has developed a state epidemiological outcomes workgroup (SEOW) that is responsible for using population-based data to guide and improve policymaking, program development, and outcomes monitoring. The SEOW workgroup is comprised of researchers from various state agencies and academia. Under guidance from the workgroup, a web-based analytic tool will be developed to increase the state's ability to access, analyze, and interpret behavioral health data. The tool will increase the state's data infrastructure to support prevention planning using the Strategic Prevention Framework (SPF) model.

3	Chronic Drunk Driving	Research suggests that long-term, intensive treatment in combination with DWI court supervision can reduce DWI recidivism (National Highway Traffic Safety Administration, 2011). In Missouri, the Serious and Repeat Offender program provides treatment for felony offenders participating in the DWI Court Program. Prior to FY 2010, the program was limited to one location in the state. In FY 2010, the Division of Alcohol and Drug Abuse requested and received approval to increase the Substance Abuse Traffic Offender Program fees to support an expansion of more intensive levels of care. In FY 2011, the state began piloting the program in other areas of the state – adding five additional contracted providers. In FY 2012, the state seeks to continue to increase access to the SROP program for chronic DWI offenders. National Highway Traffic Safety Administration (2011). An Evaluation of the Three Georgia DUI Courts. DOT HS 811 450.
4	Department of Corrections Community Supervised Offenders	The Missouri Department of Corrections (DOC) refers more individuals to publicly funded substance abuse treatment services than any other referral source. In FY 2011, more than 21,000 offenders were served through Division-contracted providers. Treating this population is of considerable importance, but the clinical needs of offenders vary widely. Given the limited capacity and access to publicly funded treatment services, it is important to develop strategies that will better align services with clinical need, and promptly identify and serve those at greatest risk to public safety because of relapse and/or recidivism potential.
5	Tobacco Sales to Minors	Approximately 28 percent of Missouri's high school seniors report smoking in the past 30 days (Missouri Department of Health and Senior Services, 2009). Research has shown that higher merchant compliance with tobacco control laws predicts lower levels of youth smoking (DiFranza, Savageau, & Fletcher, 2009). The Missouri Division of Alcohol and Drug Abuse is the state agency that oversees the state's federal Synar requirements and partners with the Division of Alcohol and Tobacco Control for tobacco control efforts. Missouri Department of Health and Senior Services (2009). Missouri 2009 Youth Tobacco Survey.
6	Recovery Oriented Systems of Care	Under the federal Access to Recovery III grant, the Division of Alcohol and Drug Abuse (ADA) has established multiple recovery oriented systems of care located across the state. These systems of care include faith-based and community-based recovery support providers that are credentialed by ADA to provide supportive services to individuals in substance abuse treatment or in recovery. Recovery support services include: family engagement, housing, peer support, transportation, re-entry coordination, recovery coaching, recovery education, spiritual counseling, spiritual life skills, and work preparation.
7	Medication Therapy	Medication therapy is the use of medications, in combination with psychosocial counseling, to support treatment and recovery from substance abuse disorders. The Missouri Division of Alcohol and Drug Abuse fully supports the use of evidence-based practices in substance abuse treatment, which includes medication therapy. Missouri now requires the public sector treatment programs to provide medication therapy, consistent with the National Quality Forum recommendations.
		Alcohol, tobacco, and other drug use is impacted by social acceptability including community laws and norms favorable toward use as well as by availability of the

8	Community Advocacy and Education	substances. Missouri's 164 community coalitions; the 11 regional support centers; and Missouri's higher education substance abuse consortium, Partnerships in Prevention (PIP) work to change community norms, policy, and substance availability in support of creating healthy, safe communities. The Regional Support Centers, in collaboration with the community coalitions, develop, implement, and evaluate a comprehensive strategic plan with identified target outcomes based on community needs. Some issues facing Missouri's communities include: 1) methamphetamine laboratories in rural parts of the state, particularly in Southeast and Southwest Missouri, 2) a growing problem with prescription drug misuse, and 3) increased availability and use of heroin in Eastern Missouri. In addition, the statewide use of tobacco products tends to be higher than that for the country as a whole.
9	Quality Improvement	Originally, the Division of Alcohol and Drug Abuse implemented the monthly Change Leaders conference call with service providers to facilitate the implementation of medication therapy. Recently, the calls have been re-tooled to take a broader perspective on innovative practices to address waiting lists, no-shows, and retention in treatment. Providers participate on a voluntary basis. Providers are encouraged to pick a NIATx aim and to develop a project to address the aim. Providers share their experiences and insight during these monthly calls that are facilitated by two ADA staff from the treatment unit.
10	IV Drug Users	The State plans to require programs receiving amounts from the SAPT Block Grant to provide services to individuals with a history of intravenous/injection drug use and to 1) report to the State, upon reaching 90 percent of its capacity, a notification of that fact within 7 days; 2) admit IV drug users within 14 days after request for services or within 120 days if interim services are made available within 48 hours; 3) establish a wait list that includes a unique patient identifier for each IV drug users seeking treatment; and 4) develop a process for maintaining contact with the IV drug users awaiting admission.
11	Tuberculosis	The State plans to require programs to establish and maintain arrangements to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery.
12	Pregnant Women and Women with Dependent Children	The State plans to require programs receiving amounts from the SAPT Block Grant to admit pregnant women and women with dependent children if sufficient capacity or to provide admission through a referral to another appropriate program or provide interim services within 48 hours of initial request for services.

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:
2011

End Year:
2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Healthcare Homes	Increase coordination and management of consumers' behavioral healthcare and primary healthcare needs	Implement Healthcare Homes a) Amend the Medicaid state plan to implement Healthcare Homes; b) Train for system change; c) Finalize Healthcare Home rules and regulations; d) Train on Healthcare Home rules and regulations; e) Develop payment process; f) Train Healthcare Home teams; g) Auto-enroll eligible consumers and develop opt-out process.	Implementation of Healthcare Homes (yes/no)	Measure considered met when Healthcare Homes begin operating and receiving per member per month payments. This is expected to occur by spring 2012. Medicaid will be providing the Department of Mental Health a file of per member per month payments by DCN and provider. As this is a new initiative, no baseline data is available. Target number of ADA consumers served in the Healthcare Homes program is 399 for FY 2012 and FY 2013.
		Develop and		

Behavioral Health Data	Increase accessibility and usability of behavioral health data	Implement a web-based analytic tool; a) Assess data availability, gaps, and comparability b) Develop a data model c) Develop user-friendly web interface d) Test system e) Place into production f) Monitor and maintain	Implementation of web-based analytic tool occurred (yes/no)	Measure considered met when the analytic tool is functional and made available for use on the public website. This is expected to occur in spring 2012. Data models have been developed for 1) census data, 2) NSDUH data, and 3) state indicator data. Data models are planned for the Missouri Student Survey data and ADA treatment data to be developed by January 2012. Testing of web pages is expected to occur in March 2012. The analytic tool is expected to be completed by May 2012.
Chronic Drunk Driving	Increase availability of long-term, intensive treatment for chronic drunk driving	Increase number of Serious and Repeat Offenders (SROP) programs across the state	Number of SROP contracted agencies, locations, and number served	Number of SROP contracts and locations and number served in SROP programs are captured in DMH information system. Baseline measures for FY 2011 are: 1) Number served = 382 2) Number of contracted agencies = 6 3) Number of sites = 24. Target numbers for FY 2012 are: 1) Number served = 442 2) Number of contracted agencies = 7 3) Number of sites = 25. Target numbers for FY 2013 are: 1) Number served = 504 2) Number of contracted agencies = 8 Number of sites = 26.
Department of Corrections Community Supervised Offenders	Improve access to clinically appropriate services	1) Assess success of the Probation and Parole Early Intervention pilot program and, subject to analysis, expand statewide. 2) Develop and implement prioritization process for offenders needing substance abuse treatment to facilitate rapid assessment and treatment initiation. 3) Assess success of the Pre-Release	1) Number served in Early Intervention pilot program; 2) Develop and implement prioritization process for offenders needing substance abuse treatment 3) Assess the Pre-Release Coordination pilot program	Number served in Early Intervention pilot program and pre-release coordination pilot are tracked in the DMH information system. The set of criteria for the prioritization process is expected to be complete by year end 2012. ADA and DOC staff meet monthly to work on prioritization and referral processes as well as any other issues impacting offenders on parole and probation seeking substance abuse treatment. In FY 2011, 19 offenders were served in the Early Intervention pilot program. The target number served for FY 2012 is 50 offenders. The Pre-Release Coordination pilot program is a new initiative and no baseline data is available. The service has been added to contracts and to the DMH information system but has not been billed yet. The target number

		Coordination pilot program and, subject to analysis, expand statewide.		served in FY 2012 is 20 offenders.
Tobacco Sales to Minors	Maintain a retailer non-compliance rate below 20 percent	Conduct enforcement and merchant education 1) Continue contracting with FDA for enforcement of federal tobacco control laws; 2) Continue partnering with the Division of Alcohol and Tobacco Control for enforcement and merchant education activities 3) Conduct a merchant education visit to every tobacco retailer in the state	Annual Synar rate is less than 20 percent (yes/no)	Measure determined from annual Synar survey. For FY 2012, this will be completed by October 2012. For FY 2013, this will be completed by October 2013.
		Maintain network of recovery support providers and matrix of recovery support services under Access to Recovery III 1) Increase the number of credentialed recovery support providers who have		Billing for recovery support services funded through the ATR III program is captured in the

Recovery Oriented Systems of Care	Provide recovery support services to promote sustained recovery	redeemed vouchers 2) Implement an electronic billing system to allow recovery support providers to submit billing and documentation through the state information system 3) Provide training and credentialing process for recovery support specialist 4) Use monthly calls for sharing of best practices for recovery service coordination	1) Number of individuals receiving recovery support services; 2) Number of credentialed recovery support providers who have redeemed vouchers	DMH information system. Baseline data for FY 2011 are: 1) Number of consumers receiving recovery support = 1,724 2) Number of credentialed recovery support providers who have redeemed vouchers = 30. Target numbers for FY 2012 and FY 2013 are: 1) Number of consumers receiving recovery support = 2,100. 2) Number of credentialed recovery support providers who have redeemed vouchers = 32.
Medication Therapy	To further integrate medication therapy into the service delivery system	1) Increase number of consumers receiving medication therapy 2) Conduct a case-control study of Medicaid consumers to demonstrate the cost benefits of Vivitrol.	1) Number of consumers receiving medication therapy; 2) Case-control study (yes/no)	Number of consumer receiving medication therapy is determined from medication billings to the DMH information system and Medicaid Claims, excluding billings occurring while in detox. Baseline for FY 2011: Number of consumers receiving medication therapy = 1,879. The target number for FY 2012 is 1,917. The target number for FY 2013 is 1,955. The case-control study will be conducted in spring 2012.
				Number of jurisdictions that have an ordinance

Community Advocacy and Education	Create positive community norms; policy change; and reduced alcohol, tobacco, and other drug availability in Missouri's communities	1) Advocate for policies that decrease access to key ingredients to manufacture methamphetamine 2) Promote tobacco cessation on Missouri's college campuses 3) Continue the Prescription Take Back Campaign 4) Continue education and awareness initiative in St. Louis to address rise in heroin-related deaths	1) Number of local ordinances requiring a prescription for pseudoephedrine; 2) Number of local ordinances prohibiting smoking in restaurants; 3) Number of nicotine quit kits distributed in conjunction with training on Missouri's college campuses	requiring a prescription for pseudoephedrine is tracked by the Department of Public Safety. Baseline is 42 as of August 8, 2011. Targets for FY 2012 and FY 2013 are 43 and 44, respectively. Number of nicotine/replacement quit kit items is tracked by Missouri's higher education substance abuse consortium, Partnerships in Prevention (PIP). As of 11/22/2011, 144 kits have been distributed. An additional 156 are planned to be distributed. Number of Prescription Take Back events is tracked by the statewide prevention resource center (ACT MO). Number of Prescription Take Back events that occurred in FY 2011 was 337. Number of Prescription Take Back events planned for FY 2012 is 337. Number of Prescription Take Back events planned for FY 2013 is 337. Number of events to educate the St Louis area on the heroin is tracked by the Eastern Regional Support Center. As this is a new initiative, no baseline data is available. The number of heroin education events planned for FY 2012 is 3.
Quality Improvement	Improve access and retention in treatment	Facilitate the development, implementation, and evaluation of NIATx projects among service providers	Number of NIATx projects implemented	Number of NIATx projects implemented by the substance abuse treatment providers will be tracked by the ADA project facilitator. As this is a new initiative, there is no baseline data. The target number of NIATx projects initiated in FY 2012 is 10. This is based on the number of participating providers. The target number of NIATx projects initiated in FY 2013 is 12.
IV Drug Users	Continue to provide substance abuse treatment services to IV drug users	Contractually require that IV drug users who have injected drugs in the prior 30 days to receive immediate admission to detoxification or residential support if clinically appropriate.	Number of IV drug users served in substance abuse treatment.	The number of IV drug users served is captured in the DMH information system. These are individuals for which a paid claim was submitted to and paid by DMH. Injection drug use is determined from the TEDS data also captured in the DMH information system. In FY 2011, 7,860 IV drug users received substance abuse treatment services. Assuming the same level of funding, the estimated number of IV drug users who receive substance abuse treatment services in FY 2012 and FY 2013 is 7,860.
		Contractually		

Tuberculosis	Continue to provide TB services to individuals in substance abuse treatment	require programs to 1) have a working relationship with the local health department, physician, or other qualified healthcare provider in the community to provide any necessary testing services for tuberculosis, 2) arrange for TB testing to be available to the client at any time during the course of the client's treatment, 3) provide post-testing counseling for clients testing positive, and 4) provide education to clients and family members on the risks of tuberculosis.	Number of individuals receiving TB test counseling.	The number of individuals receiving TB test counseling is captured in the DMH information system. These are individuals for which a paid claim for TB counseling services was submitted to and paid by DMH. In FY 2011, 3,107 individuals received TB counseling as part of their substance abuse treatment program. Assuming the same level of funding, the estimated number who will receive TB counseling services in FY 2012 and FY 2013 is 3,107.
		The State plans to require programs		

Pregnant Women and Women with Dependent Children	Continue to provide services to pregnant women and women with dependent children	receiving amounts from the SAPT Block Grant to admit pregnant women and women with dependent children if sufficient capacity or to provide admission through a referral to another appropriate program or provide interim services within 48 hours of initial request for services.	Number of pregnant women and women with dependent children served in substance abuse treatment.	The number of pregnant women and women with dependent children served is captured in the DMH information system. These are individuals for which a paid claim was submitted to and paid by DMH. Pregnancy status and number of dependent children is also captured. In FY 2011, 6,319 pregnant women or women with dependent children received substance abuse treatment services. Assuming the same level of funding, the estimated number of pregnant women and women with dependent children who will be served in substance abuse treatment in FY 2012 and FY 2013 is 6,319.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy

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Start Year:
2011

End Year:
2013

Reimbursement Strategy	Services Purchased Using the Strategy	Other
No Data Available		

Footnotes:

Missouri will work to submit this information in the FY 2014 SAPT Block Grant application.

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 Projected Expenditures for Treatment and Recovery Supports

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Start Year: 2011

End Year: 2013

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	N/A 6
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	N/A 6
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	N/A 6
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	N/A 6
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	N/A 6
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	N/A 6
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	N/A 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	N/A 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	N/A 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	N/A 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	N/A 6
System improvement activities		N/A 6
Other		N/A 6

Footnotes:

The state will work to respond to this item in the FY 2014 application.

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 Primary Prevention Planned Expenditures Checklist

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Start Year: 2011

End Year: 2013

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$411,351	$169,924	$143,960	$	$
Information Dissemination	Selective	$190,054	$	$31,972	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$601,405	$169,924	$175,932	$	$
Education	Universal	$1,009,878	$52,187	$253,804	$	$
Education	Selective	$1,040,978	$227,476	$11,146	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$2,050,856	$279,663	$264,950	$	$
Alternatives	Universal	$27,055	$	$7,370	$	$
Alternatives	Selective	$259,127	$	$1,534	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$286,182	$	$8,904	$	$
Problem Identification and Referral	Universal	$27,721	$	$1,810	$	$
Problem Identification and Referral	Selective	$13,019	$	$252	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$40,740	$	$2,062	$	$

Community-Based Process	Universal	$956,377	$136,568	$381,134	$	$
Community-Based Process	Selective	$140,778	$	$75,554	$	$
Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$1,097,155	$136,568	$456,688	$	$
Environmental	Universal	$367,835	$	$85,980	$	$
Environmental	Selective	$47,633	$44,174	$42,870	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$415,468	$44,174	$128,850	$	$
Section 1926 Tobacco	Universal	$326,565	$	$552,116	$	$
Section 1926 Tobacco	Selective	$23,813	$	$66,358	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$350,378	$	$618,474	$	$
Other	Universal	$290,152	$137,933	$105,324	$	$
Other	Selective	$70,865	$1,095,673	$21,274	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$361,017	$1,233,606	$126,598	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 Projected State Agency Expenditure Report

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Start Year: 2011

End Year: 2013

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$19,507,759	$62,850,690	$21,694,688	$73,463,210	$	$
2. Primary Prevention	$5,203,201	$	$7,010,606	$1,782,458	$	$
3. Tuberculosis Services	$4,244	$36,676	$1,868	$23,878	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$1,300,800	$	$3,560,620	$2,720,938	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$26,016,004	$62,887,366	$32,267,782	$77,990,484	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$1,300,800	$	$3,560,620	$2,720,938	$	$
11. Total	$26,016,004	$62,887,366	$32,267,782	$77,990,484	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditure Checklist

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Start Year: 2011

End Year: 2013

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment		$ 321,360		$		$321,360
2. Quality Assurance		$		$		$
3. Training (Post-Employment)		$		$		$
4. Education (Pre-Employment)		$		$		$
5. Program Development		$ 364,272		$ 9,968		$374,240
6. Research and Evaluation		$ 132,495		$		$132,495
7. Information Systems		$		$		$
8. Total	$	$818,127	$	$9,968	$	$828,095

Footnotes:

The amounts listed for this table reflect only funds used from the FY 2012 SAPT Block Grant.

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

Activities that Support Individuals in Directing the Services

Person Centered planning is an important focus for the Missouri Department of Mental Health (DMH) - Division of Alcohol and Drug Abuse. One of the DMH core values is "Partners in Personal Service Design: Missourians participating in mental health services are active partners in designing their services and supports." In 2006, Missouri received a SAMHSA-funded Mental Health Transformation Improvement Grant. In addition to mental health, the State included substance abuse and developmental disabilities in its transformation planning process. In Missouri's Comprehensive Plan for Mental Health 2008-2013, a goal is that Missouri's mental health care is consumer and family driven with 1) increased consumer decision-making and self directed care; 2) expanded and integrated peer and family support services; 3) the creation of a culture of respect, dignity, and wellness as the milieu in which all mental health services are provided; and 4) increased number of consumers fully participating in the development, implementation, and evaluation of the system. Each year the Department of Mental Health sponsors an annual Consumer/Family and Youth Leadership Conference to promote consumer voice and advocacy. The 2011 conference, held August 21-23, was attended by about 450 participants.

In support of Missouri's Access to Recovery (ATR) III program, trainings are being conducted by the Missouri Substance Abuse Professional Credentialing Board in recovery oriented systems of care (ROSC) – which includes elements of person centered planning. A ROSC training was conducted at the 2011 Consumer/Family and Youth Leadership Conference. Other ROSC trainings are being conducted around the state. In addition, several of the state's certification standards for Alcohol and Drug Abuse Programs address aspects of self-directed care. The Division of Alcohol and Drug Abuse continues to work to support and promote person centered planning in its service delivery model. Currently, the DMH information system does not specifically identify consumers that self direct their care.

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

Data and Information Technology

In October 2006, the Department of Mental Health (DMH) replaced approximately 15 legacy systems with a web-based information system called Customer Information Management Outcomes and Reporting (CIMOR) system. CIMOR provides for the intake and tracking of consumers – including admission, level changes, and discharge – collection of Treatment Episode Dataset (TEDS) data, state facility bed management, event tracking for incidents impacting consumer safety, clinical screening and assessments, recording of diagnostic information for both DSM-IV and ICD-9 code sets, tracking of court commitments, recording of clinical encounters, authorization request and approval processes, maintenance and tracking of department funding and program expenditures, claims adjunction and payment, voucher management and Government Performance and Reporting Act (GPRA) data collection for the federal Access to Recovery III program, tracking of Medicaid benefit eligibility, consumer banking for management of consumer funds held in trust by state facilities, provider management, standard means test (SMT) application, outcomes reporting, and waiting lists. Encounters do capture type, amount, and cost of service provided, date provided, and location of service delivery. CIMOR captures reimbursable medications for non-Medicaid consumers but not for non-reimbursable medications. For Medicaid consumers, pharmacies direct bill the state Medicaid agency.

Authorized DMH staff have access to CyberAccess, which is an electronic health record for Medicaid consumers. CyberAccess is a web-based, HIPAA compliant portal that enables users to view the complete medical and drug claim history for Medicaid fee-for-service participants. The claim history is extracted from paid claims and goes back approximately two years. CyberAccess allows direct Medicaid consumer lookup. In addition, DMH receives Medicaid claims data in batch bi-monthly, which is loaded onto the data warehouse to support the department's data analytics and reporting activities. Reports are generated from CIMOR data and from Medicaid claims data. Currently, there are no plans to develop electronic health records in CIMOR due, in part, to limited resources.

CIMOR was designed to comply with federal security and privacy requirements. Security in CIMOR is role-based and access to screens and functions is dependent upon one's job duties. CIMOR interfaces with Medicaid eligibility data from the Department of Social Services to determine benefits eligibility and with social security number (SSN) data from the Social Security Administration for SSN verification. As of April 2011, all three divisions of the DMH are using CIMOR.

The Division of Alcohol and Drug Abuse requires contracted substance abuse treatment providers to obtain national provider identifiers which are maintained in CIMOR. CIMOR also maintains the Inventory of Substance Abuse Treatment Services (I-SATS) identifier assigned to treatment sites for TEDS reporting. In addition, CIMOR assigns all organizations a unique identifier primarily for internal use. All consumers receive a unique identifier that is permanently assigned and maintained by CIMOR and is used by all three DMH divisions. CIMOR also collects the Department of Corrections identifier

for parolees and probationers, driver's license number for DWI traffic offenders, DCN for Medicaid consumers, and SSN on all ADA consumers.

Missouri does have a grant to create a statewide health information exchange. Missouri Health Connection, a non-profit 501(c)3 organization, has been awarded $13.8 million in federal funding for the planning and development of a statewide health information exchange. DMH's Deputy General Counsel & Privacy Officer serves on the Legal and Policy Workgroup. Representatives from DMH contracted service providers also serve on the Board of Directors, Technology & Operations Workgroup, and the Finance Committee.

IV: Narrative Plan

F. Quality Improvement Reporting

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Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

Quality Improvement Reporting

The Continuous Quality Improvement (CQI) Plan for the Division of Alcohol and Drug Abuse (ADA) / Comprehensive Psychiatric Services (CPS) is currently in draft status. A copy of the plan will be submitted to the Substance Abuse and Mental Health Services Administration once the plan has been finalized. The Division Director has appointed a Director of Performance Improvement for ADA/CPS. It is the responsibility of the Performance Director to coordinate the efforts of the CQI team, to write the performance improvement plan, and to record updates to that plan annually. The CQI Plan is expected to be finalized prior to March 1, 2012.

IV: Narrative Plan

G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

Consultation with Tribes

The state of Missouri does not have any federally recognized tribal governments or tribal lands within its borders.

IV: Narrative Plan

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

Service Management Strategies

The Division of Alcohol and Drug Abuse (ADA) continues to mine encounter data to identify trends in utilization of Substance Abuse Prevention and Treatment Block Grant funded services. Routine and on-demand reports are provided to the ADA management team for their review and to support their decision-making processes. Follow-up with service providers and technical assistance, as needed, are generally provided by Regional Administrators and Area Treatment Coordinators. Data analysis, reporting, and review are on-going. Working closely with the ADA fiscal and clinical treatment units, ADA research analysts skilled in SAS, relational database, GIS, and SQL support this activity. ADA continues to work toward further development and enhancement of its utilization management strategies.

IV: Narrative Plan

I. State Dashboards (Table 10)

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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year:

Priority	Performance Indicator	Selected
Healthcare Homes	Implementation of Healthcare Homes (yes/no)	é
Behavioral Health Data	Implementation of web-based analytic tool occurred (yes/no)	é
Chronic Drunk Driving	Number of SROP contracted agencies, locations, and number served	é
Department of Corrections Community Supervised Offenders	1) Number served in Early Intervention pilot program; 2) Develop and implement prioritization process for offenders needing substance abuse treatment 3) Assess the Pre-Release Coordination pilot program	é
Tobacco Sales to Minors	Annual Synar rate is less than 20 percent (yes/no)	é
Recovery Oriented Systems of Care	1) Number of individuals receiving recovery support services; 2) Number of credentialed recovery support providers who have redeemed vouchers	é
Medication Therapy	1) Number of consumers receiving medication therapy; 2) Case-control study (yes/no)	é
Community Advocacy and Education	1) Number of local ordinances requiring a prescription for pseudoephedrine; 2) Number of local ordinances prohibiting smoking in restaurants; 3) Number of nicotine quit kits distributed in conjunction with training on Missouri's college campuses	é
Quality Improvement	Number of NIATx projects implemented	é
IV Drug Users	Number of IV drug users served in substance abuse treatment.	é
Tuberculosis	Number of individuals receiving TB test counseling.	é
Pregnant Women and Women with Dependent Children	Number of pregnant women and women with dependent children served in substance abuse treatment.	é

Footnotes:

State Dashboards

Missouri Department of Mental Health – Division of Alcohol and Drug Abuse (ADA) will continue to measure the National Outcome Measures. Over the course of the next year and half, ADA will monitor and access its performance indicators as identified in its FY 2012 State Plan and will seek to establish a state dashboard in the FY 2014 State Plan.

IV: Narrative Plan

J. Suicide Prevention

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Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

Suicide Prevention

Missouri's most recent suicide prevention plan ended in 2010. Work began on an updated plan in 2010 but that work was suspended pending the outcome of a proposal to eliminate the Suicide Prevention Advisory Committee. The committee was officially eliminated in summer 2011 with its primary functions being transferred to the Division of Comprehensive Services (CPS) State Advisory Council (SAC). The tentative timeline to update the state's suicide prevention plan is as follows:

Date(s)	Action
January 31, 2012	Complete the Draft Plan
February 2012	Seek Feedback on Draft from Stakeholders
March 15, 2012	Finalize and Issue Revised Plan

IV: Narrative Plan

K. Technical Assistance Needs

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Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

Technical Assistance Needs

The State has not currently identified any technical assistance needs related to the proposed plan. If technical assistance needs are identified in the future, the State will notify SAMHSA.

IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

Involvement of Individuals and Families

Several rules for Alcohol and Drug Abuse Program certification address family involvement in the delivery of substance abuse treatment. Most prominently, family involvement is identified as an "essential treatment principle" in the core rules for both psychiatric and substance abuse programs certified in Missouri. Consumers accessing Missouri's substance abuse treatment and recovery support system of care receive an assessment to determine individual needs including needs related to family relationships. The assessment, with consumer input, helps drive the service plan. In substance abuse treatment, both family therapy and collateral dependent (individual and group) counseling are reimbursable services available to promote healthy family relationships.

As part of Missouri's Access to Recovery III program, peer support services involving recovery-based or spiritual-based face-to-face interaction between a peer and a consumer are provided to help consumers achieve and maintain recovery. In addition, recovery coaching services use a peer supportive relationship to help the consumer develop recovery skills. In Missouri, recovery coaches are credentialed as Missouri Recovery Support Specialists (MRSS) through Missouri Substance Abuse Professional Credentialing Board. The Division of Alcohol and Drug Abuse (ADA) sponsors trainings, funded through the ATR III program, which are available at no charge for ATR III direct care staff and are available to other direct care staff at a nominal fee. Topics for these trainings include, but are not limited to, stages of change, family engagement, recovery coaching, and spirituality.

In 2006, Missouri received a SAMHSA-funded Mental Health Transformation Improvement Grant. In addition to mental health, the State included substance abuse and developmental disabilities in its transformation planning process. In Missouri's Comprehensive Plan for Mental Health 2008-2013, a goal is that Missouri's mental health care is consumer and family driven with 1) increased consumer decision-making and self directed care; 2) expanded and integrated peer and family support services; 3) the creation of a culture of respect, dignity, and wellness as the milieu in which all mental health services are provided; and 4) increased number of consumers fully participating in the development, implementation, and evaluation of the system. Each year the Department of Mental Health sponsors an annual Consumer/Family and Youth Leadership Conference to promote consumer voice and advocacy. The 2011 conference, held August 21-23, was attended by about 450 participants.

ADA also sponsors the Missouri Recovery Network (MRN), a statewide organization that provides an opportunity for individuals in recovery, their families, friends, and other supportive people to advocate for a "good and modern" system of care, reduce the stigma of addiction, and reduce other barriers to recovery. MRN educates its members on the legislative process, how to communicate with elected officials, and how to communicate a message or story. MRN also hosts special events and gatherings in communities throughout the state. These include picnics, seminars/conferences, festivals, ball games, and walks.

In recognizing that healthy family and personal relationships are vital to recovery, ADA continues to work to expand efforts to incorporate families into the broader recovery system.

IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

Use of Technology

Access to substance abuse treatment services is a significant obstacle to many individuals who reside in rural and/or geographically isolated areas of the state. In addition, Missouri struggles with a shortage of a workforce qualified to deliver services consistent with a comprehensive system of care, particularly, licensed mental health professionals and licensed medical professionals. It is inefficient to pay such professionals for significant travel time to deliver services to more remote areas. Thus, the state is supporting providers who expand service accessibility through telehealth. Several providers have been delivering such services for more than a year using non-Medicaid funds. The Division of ADA recently submitted to the state's Medicaid agency a request to revise state regulations to allow reimbursement for select substance abuse treatment services delivered via telehealth in approved programs by qualified providers.

IV: Narrative Plan

N. Support of State Partners

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Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

Support of State Partners

The Missouri Department of Mental Health (DMH) has strategic partnerships with its sister agencies including the Department of Social Services, the Department of Health and Senior Services, the Department of Elementary and Secondary Education, the Department of Corrections, the Department of Public Safety, the Office of State Court Administrators, and the Department of Insurance, and the Office of Administration. DMH has had formal written memorandums of understanding with many of these agencies.

Health Homes

DMH is working very closely with the Department of Social Services (DSS), MO HealthNet (Medicaid) to develop the Health Home State Plan Amendment for Community Mental Health Centers, many of which are contracted with ADA to provide CSTAR treatment. There is weekly and sometimes daily contact for the planning and implementation of Health Reform. Details about the Health Homes and documents already developed including the State Plan Amendment are on the DMH website at http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm.

Partners in developing Missouri Health Homes are:

- Michael Bailit of Bailit Health Purchasing
- Alicia Smith of Health Management Associates
- Missouri Coalition of Community Mental Health Centers
- Missouri Primary Care Association
- ACS Heritage
- Care Management Technologies “CMT”
- Missouri Foundation for Health

Missouri Coalition of Community Mental Health Centers, Missouri Institute of Mental Health, Missouri Foundation for Health, and Missouri Primary Care Association are consistent partners with DMH in improving healthcare for Missourians.

Mental Health Transformation

The state of Missouri was awarded a Mental Health Transformation Grant by the Substance Abuse and Mental Health Services Administration (SAMHSA) for five years, effective October 1, 2006. The five year grant has helped support building an infrastructure required for transformation, such as planning, workforce development, evidence-based practice implementation, and technology enhancements. The common goals are to foster communities of hope through cooperation and collaboration of effort, and to employ a public health approach to mental health service delivery, including addiction services. Missouri is one of nine states to receive a five-year federal grant for the transformation of its mental health service system. Though based in the state Department of Mental Health, this system involves all human service agencies whose objective is improved quality of life for the citizens of this state. A Human Services Cabinet Council (the “Council”) was established; composed of cabinet-level directors of the Departments of Mental Health, Health and Senior Services, Social Services,

Elementary and Secondary Education, Corrections and Public Safety. State information technology director also participates on the Council to support the work of the grant as does a designee from the Governor's office. The purpose of the Council was to review cross-department policy and operations related to human services and to develop and implement a comprehensive state mental health plan. This has been accomplished and details can be found on the DMH website at:

http://missouridmh.typepad.com/transformation/.

Department of Corrections

DMH and the Department of Corrections (DOC) maintain a memorandum of understanding to coordinate monitoring and review of community-based addiction programs that serve offenders under community supervision. The agreement provides for the transfer of DOC substance abuse community services funding to DMH. DMH is required to monitor appropriation balances to assure funds are expended appropriately and provide DOC with quarterly reports on utilization of contract funds. The agreement also requires DMH and DOC to establish a process for referring offenders to treatment.

Department of Elementary and Secondary Education

In recent years, DMH and the Department of Elementary and Secondary Education (DESE) have established memoranda of understanding for the administration of the Missouri Student Survey (MSS). The agreements have authorized DMH to use DESE federal Safe and Drug Free Schools and Communities funds to procure the services of a contractor to administer the Missouri Student Survey to eligible public school students. Survey administration included having the survey instrument available for completion on the designated days at the designated times, collecting completed surveys, compiling and analyzing survey data, production of a survey report, and transfer of all survey data to DESE. DMH hopes to continue the MSS survey in future years even though the Safe and Drug Free School funds are no longer available.

Department of Public Safety

DMH subcontracts with the Department of Public Safety (DPS) for the enforcement of the federal Family Smoking Prevention and Tobacco Control Act. DMH has loaned DPS four full-time equivalent positions for the sole purpose of enforcing federal and state tobacco regulations to include federal advertising and labeling inspections and state and federal undercover buy inspections. This activity is in support of DMH's Synar program.

In addition, DMH as the public mental health authority leads the mental health response for disasters in Missouri. The Department continues to plan for its own facilities and for a statewide response. In addition, DMH is working cooperatively with other state agencies to plan for disasters and public health emergencies as well as to develop and provide training. Collaboration occurs with the Department of Health and Senior

Services, the Department of Public Safety, the Department of Agriculture, universities, school personnel, clergy, public health nurses, and mental health centers.

IV: Narrative Plan

O. State Behavioral Health Advisory Council

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Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

State Behavioral Health Advisory Council

The State Advisory Council serves as an advisory body to the Division of Alcohol and Drug Abuse (ADA) and the division director on policy, prevention, and treatment activities in the state of Missouri. The Council is created by Missouri Statute (RsMO 631.020). The council is comprised of up to twenty-five members appointed by the Director of ADA. Members have professional, research, and/or personal interests in the division's purpose. At least one-half of the members shall be consumers, and one member shall represent veterans and military affairs. No more than one-fourth of the members shall be vendors or members of boards of directors, employees or officers of vendors, or spouses of any of the above mentioned, if such vendors received more than fifteen hundred dollars ($1,500) per year under contract with the Department of Mental Health. Members of boards of directors of not-for-profit corporations shall not be considered vendors. Each member shall be appointed for an initial term of one, two, or three years to allow for a rotation of one-third of the members each year. Each member serves until a successor has been appointed.

A separate SAC advises the Division of Comprehensive Psychiatric Services (CPS) in the development and coordination of a statewide inter-agency and inter-departmental system of care for children and youth with serious emotional disorders and adults with mental illness. In support of integration of ADA and CPS administrative functions, considerations are being made for the future integration of the SAC's. During the past year, the CPS and ADA SAC's have conducted joint subcommittee meetings to develop recommendations for the integration of the SAC's. To integrate the two councils will take legislative changes to the state statutes. In addition, changes to the SAC structure must consider federal requirements for such councils.

IV: Narrative Plan

Table 11 List of Advisory Council Members

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Start Year: 2011

End Year: 2013

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Clif Johnson	Providers	Southeast Missouri Behavioral Health	PO Box 506, 512 East Main Street Park Hills, MO 63601 PH: 573-431-0554	
Ladell Flowers	Providers	Dismas House of Kansas City Inc.	301 E Armour Blvd Kansas City, MO 64111 PH: 816-531-6050	Lflowers@dismashousekc.com
Benjamin Bruening	State Employees	Missouri National Guard	1225 Cooper Dr Jefferson City, MO 65101 PH: 573-638-9500	benjamin.t.bruening@us.army.mil
Marilyn Gibson	State Employees	Circuit Court, 31st Judicial Circuit Court	1010 Boonville Ave Springfield, MO 65804-3804 PH: 417-576-7637	marilyn.gibson@courts.mo.gov
Cynthia Steuber	State Employees	Department of Corrections, CTCC	PO Box 70 Fulton, MO 65251 PH: 573-592-4018	cindy.steuber@doc.mo.gov
Edgar Hagens	Individuals in Recovery (from Mental Illness and Addictions)		Springfield, MO	
Michael Carter	State Employees	Department of Health and Senior Services	149 Park Central Square, Ste 116 Springfield, MO 65806 PH: 417-895-6968	mike.carter@dhss.mo.gov

Cheryl Gardine	Providers	Center for Life Solutions	3129 Edwards Place #304 Maryland Heights, MO 63043 PH: 314-731-0100	cheryl@centerforlifesolutions.org
Sylvia Persky	Individuals in Recovery (from Mental Illness and Addictions)		MO PH: 417-840-6322	sylviemae@gmail.com
Stephen Doherty	Providers	Gateway Foundation	1430 Olive St, Suite 300 St Louis, MO 63103 PH: 314-421-6188	sdoherty@gatewayfoundation.org
Diana Harris	State Employees	Department of Corrections	220 South Jefferson Ave St Louis, MO 63103 PH: 314-877-1176	diana.harris@doc.mo.gov
Robin Hammond	Others (Not State employees or providers)	St Joseph Youth Alliance	3308 S Leonard Rd St Joseph, MO 64503 PH: 816-232-0050	rhammond@youth-alliance.org
Sandra Hentges	State Employees	Department of Health and Senior Services	930 Wildwood Dr Jefferson City, MO 65109 PH: 573-751-6150	hentgs@dhss.mo.gov
Dana Carter	Others (Not State employees or providers)	Carter Counseling, LLC	1502 E Broadway, Suite 210 Columbia, MO 65201 PH: 573-777-1105	cartercounseling@gmail.com
Percy Menzies	Providers	Assisted Recovery Centers of America	Chippewa St, Suite 224 St. Louis, MO 63109 PH: 314-645-6840	percymenzies@arcamidwest.com
Thomas Casey	Individuals in Recovery (from Mental Illness and Addictions)		9041 McKnight Woods Richmond Heights, MO 63117 PH: 314-421-0763	Tcasey01@earthlink.net
Nancy Johnson	Others (Not State employees or providers)	Truman State University	1101 Greenway Dr Kirksville, MO 63501 PH: 660-988-2090	nkr323@gmail.com
Theresa Eschmann	Others (Not State employees or providers)	Advanced Psychiatric Services	807 Collins Rd Festus, MO 63028 PH: 636-931-4206	webjan6@msn.com

Dave Brown	Others (Not State employees or providers)	Missouri Western State University	4525 Downs Dr St Joseph, MO 64507 PH: 816-271-4327	brownday@missouriwestern.edu
Sandra Jackson	Others (Not State employees or providers)	John J Pershing Veteran's Administration	1500 N Westwood Blvd Poplar Bluff, MO 63901 PH: 573-778-4740	sandra.jackson@va.gov
Phillip Britt	State Employees	35th Judicial Circuit Treatment Courts	35th Judicial Circuit Treatment Courts, PO Box 805 Kennett, MO 63857 PH: 573-888-6882	philip.britt@courts.mo.gov

Footnotes:

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

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Start Year: 2011

End Year: 2013

Type of Membership	Number	Percentage
Total Membership	21	
Individuals in Recovery (from Mental Illness and Addictions)	3	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	0	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	6	
Total Individuals in Recovery, Family Members & Others	9	42.86%
State Employees	7	
Providers	5	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	12	57.14%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

Comment on State Plan

The Missouri Advisory Council on Alcohol and Drug Abuse, commonly referred to as the State Advisory Council (SAC) constitutes the formal mechanism that ensures that Missouri citizens have an opportunity to participate in and express their views regarding the state's publicly funded substance abuse prevention and treatment system managed by the Missouri Division of Alcohol and Drug Abuse (ADA). The SAC's statutory mandate is to collaborate with ADA to disseminate public information about alcohol and drug abuse; review current social technologies and recommend improvements to substance abuse prevention and treatment programs based upon scientific evidence; recommend what should be changed and how to improve and update the substance abuse service delivery system; and participate in developing standards for prevention and treatment services.

The SAC has 25 members consisting of service providers, consumers (recipients of services or family members of recipients), and other interested citizens. Most SAC members have leadership roles as managers, advocates or volunteers in the substance abuse service delivery system. Current representation includes consumers; treatment, recovery support, and prevention service providers; the Missouri National Guard; the Department of Corrections; the Veteran's Administration; drug court; the Department of Health and Senior Services; the Department of Elementary and Secondary Education; and academia. The SAC meets regularly and holds conference calls to receive updates from ADA staff and provide feedback on budget-related matters, legislative initiatives, strategic planning, performance measurement development, and other aspects of service delivery system. The SAC chairperson appoints ad hoc committees as needed to address priority issues and make recommendations to ADA. SAC members continually seek input from individuals, agencies, and organizations impacted by substance abuse.

After review by ADA management, the state plan is submitted to the SAC for its review and feedback prior to submission to the Substance Abuse and Mental Health Services Administration. To facilitate ongoing review, each Block Grant application is posted to the ADA public website at http://www.dmh.missouri.gov/ada/blockgrant.htm. The array of links to current and past block grant applications is preceded by a narrative that explains the purpose of the block grant and solicits comments from any interested persons (http://www.dmh.missouri.gov/ada/reportsstatistics.htm#blockgrant.). The solicitation for comments is worded as:

The CSAT requires each state to have a process to facilitate public comment in developing the plan and the application for Block Grant funds. The Division encourages interested persons to review the application and submit comments and suggestions that can be considered for inclusion in the next Block Grant application submission. Please mail your comments to: Director, Division of Alcohol and Drug Abuse; P.O. Box 687;

Jefferson City, MO 65102. *You can also e-mail your comments to:* adamail@dmh.mo.gov.

Missouri

UNIFORM APPLICATION
FY2012

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

42 U.S.C.300x-21 through 300x-66

OMB - Approved 07/20/2010 - Expires 07/31/2013

(generated on 5/4/2012 2:39:33 PM)

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Center for Substance Abuse Prevention

Introduction:

The Substance Abuse Prevention and Treatment Block Grant represents a significant Federal contribution to the States' substance abuse prevention and treatment service budgets. The Public Health Service Act [42 USC 300x-21 through 300x-66] authorizes the Substance Abuse Prevention and Treatment Block Grant and specifies requirements attached to the use of these funds. The SAPT Block Grant funds are annually authorized under separate appropriation by Congress. The Public Health Service Act designates the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention as the entities responsible for administering the SAPT Block Grant program.

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-66), as implemented by the Interim Final Rule (45 CFR Part 96, part XI). With regard to the requirements for Goal 8, the Annual Synar Report format provides the means for States to comply with the reporting provisions of the Synar Amendment (Section 1926 of the Public Health Service Act), as implemented by the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, part IV).

Public reporting burden for this collection of information is estimated to average 454 hours per respondent for Sections I-II, 40 hours per respondent for Section III-A and 42.75 hours per respondent for Section III-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (OMB No. 0930-0080), 1 Choke Cherry Road, Room 7-1042, Rockville, Maryland 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is OMB No. 0930-0080.

The Web Block Grant Application System (Web BGAS) has been developed to facilitate States' completion, submission and revision of their Block Grant application. The Web BGAS can be accessed via the World Wide Web at http://bgas.samhsa.gov.

Form 1

DUNS Number: 780871430-

Uniform Application for FY 2012-14 Substance Abuse Prevention and Treatment Block Grant

I. State Agency to be the Grantee for the Block Grant:

Agency Name:	Missouri Department of Mental Health
Organizational Unit:	Division of Alcohol and Drug Abuse
Mailing Address:	1706 E. Elm Street, P.O. Box 687
City:	Jefferson City Zip Code: 65102-0687

II. Contact Person for the Grantee of the Block Grant:

Name:	Mark Stringer
Agency Name:	Missouri Department of Mental Health Div. of Alcohol and Drug Abuse
Mailing Address:	1706 E. Elm Street, P.O. Box 687
City:	Jefferson City Code: 65102-0687
Telephone:	(573) 751-9499 FAX: (573) 751-7814
Email Address:	mark.stringer@dmh.mo.gov

III. State Expenditure Period:

From: 7/1/2009 To: 6/30/2010

IV. Date Submitted:

Date: 9/28/2010 1:54:06 PM Original: ◉ Revision: ○

V. Contact Person Responsible for Application Submission:

Name:	Mark Stringer	Telephone:	(573) 751-9499
Email Address:	mark.stringer@dmh.mo.gov	FAX:	(573) 751-7814

Form 2 (Table of Contents)

Goal #1: Improving access to Prevention and Treatment Services

The State shall expend block grant funds to maintain a continuum of substance abuse prevention and treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded prevention (with the exception of primary prevention; see Goal # 2 below) and treatment services available in the State (See 42 U.S.C. §300x-21(b) and 45 C.F.R. §96.122(f)(g)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to: *Providing comprehensive services; Using funds to purchase specialty program(s); Developing/maintaining contracts with providers; Providing local appropriations; Conducting training and/or technical assistance; Developing needs assessment information; Convening advisory groups, work groups, councils, or boards; Providing informational forum(s); and/or Conducting provider audits.*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

During FY 2009, the Missouri Division of Alcohol and Drug Abuse (ADA) supported a strong continuum of substance abuse treatment services through contracts with private treatment providers. Treatment services are made available at locations throughout the state based on needs assessments and the availability of qualified care providers. Treatment and support services were delivered via 38 Primary Recovery Plus (PR+) contracts and 22 Comprehensive Substance Treatment and Rehabilitation (CSTAR) contracts, which includes three opioid treatment providers. There were 88 contracts issued to providers of recovery support services.

The PR+ contracts were reduced through consolidations and timing. The reduction of CSTAR contracts is due to the department decision to consolidate the multiple CSTAR contracts (General Population, Women & Children, Adolescent, Opioid) at providers to one CSTAR contract covering all CSTAR services at the specific provider. Much of the reduction of recovery support contracts is due to transitioning between ATR I and ATR II with existing providers. Additionally there were more ATR I providers than ATR II providers.

Clinical Outreach

Many individuals are in need of services but are uncertain of this need or are unsure how to access services. The Division of ADA reimburses agencies for providing clinical outreach activities which may include assessment, consultation, coordination, and referral. These activities are directed to individuals who are not enrolled as Division of Alcohol and Drug Abuse consumers; individuals using intravenous drugs; and, ADA consumers living in certain subsidized housing. Specific outreach activities conducted face-to-face by either a qualified substance abuse professional or a community support worker are the following:

- Contacts with staff and consumers of DMH psychiatric hospitals, habilitation centers, and community mental health centers;
- Contacts with child welfare and TANF staff and referrals;
- In-home monitoring and case management for DMH consumers residing in Shelter Care Plus and Section 8 housing;
- Activities directed toward intravenous drug users to promote their engagement in substance abuse treatment; and
- For Women's and Children's Programs, contact staff at medical facilities working with pregnant women (e.g., hospitals, clinics, local health departments, OB/GYN physicians).

Detoxification

Often the first step towards recovery, detoxification services assist consumers in withdrawing from addictive substances in a safe, supportive, and closely monitored environment. At admission, trained staff assess a consumer's need for detoxification

services utilizing physician-approved protocols. This assessment guides the individual's placement into an appropriate level of care given the consumer's physical and mental needs. The types of publicly-funded detoxification programs available in Missouri are modified medical and social setting. During the course of detoxification, consumers are assisted in making arrangements for continuing treatment.

CSTAR

Developed by ADA and funded by Missouri's Medicaid program and ADA's Purchase of Service system, the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program provides a continuum of care approach to substance abuse treatment. CSTAR offers a flexible combination of clinical and supportive services, to include temporary living arrangements when appropriate, that vary in duration and intensity depending on the needs of the consumer. Available services include assessment; individual and group counseling; group education; community support; residential or housing support, as appropriate; trauma-specific individual counseling and group education; individual co-occurring disorders counseling; family therapy; medications, physician and nursing services specific to medication-assisted treatment. In addition, families can also participate in individual and group codependency counseling.

In FY 2009, there were four different types of CSTAR programs available in Missouri: women and children, adolescent, general population, and opioid. All offer three graduated levels of care. All but the opioid programs offer a residential component for individuals needing that kind of structure and support. Consumers can enter the program at any level and move between levels depending on their assessed needs, problem severity and treatment progress.

CSTAR Women and Children's Treatment Programs

Substance abuse can affect women differently than men, both physically and psychologically. Specialized CSTAR programs are offered for women and their children with programming that is tailored to this population. Pregnant women and women with children in their care are prioritized populations. The full array of services is available and is individualized to the consumer's unique needs. In addition, daycare is provided to ensure childcare is not an obstacle to treatment participation. Alternative Care (Alt Care) is a more specialized type of women and children's program that resulted from a joint effort through ADA and the Missouri Department of Corrections. Alt Care is designed specifically for female offenders being released from correctional institutions and those under probationary supervision. There is one program in each of Missouri's two metro areas, St Louis and Kansas City.

CSTAR Adolescent Programs

Adolescent CSTAR programs offer a full continuum of services provided by specially trained staff to consumers 12 to 17 years of age. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Consumers in residential settings are offered academic support services to minimize disruptions in their education.

CSTAR General Population Programs
CSTAR General Population programs offer the complete array of substance abuse treatment and supportive services to men and women receiving Medicaid.

CSTAR Opioid Programs
Opioid programs utilize physician-prescribed methadone to assist opiate-addicted consumers withdraw from these drugs while under medical supervision. Addiction treatment services are provided during and after the withdrawal protocol to help the individuals develop life skills and a recovery-focused lifestyle. Missouri's opioid treatment programs comply with applicable federal guidelines.

Primary Recovery and Primary Recovery Plus (PR+)
Missouri's Primary Recovery programs offer a full continuum services within multiple levels of care, modeled after the CSTAR program. Detoxification services are available to any Missourian in need, but are accessed through the PR+ providers. In FY 2009, four providers were offering modified medical detoxification services versus social setting detoxification. Missouri's receipt of the Access to Recovery (ATR) grant supported the implementation of the ATR goals into the PR+ programs. The goals of the grant were to promote consumer choice of treatment and recovery support providers, expand access to a comprehensive array of treatment and support options, to include faith-based and non-traditional programs, and increase substance abuse treatment capacity.

State regulations pertinent to substance abuse treatment and prevention can be found in the Code of State Regulations (CSR) 9 CSR 30-3 which are on file with the Missouri Secretary of State: http://www.sos.mo.gov/adrules/csr/current/9csr/9c30-3.pdf.

Early Intervention
Early FY 2009 marked the formal end to the Robert Wood Johnson Foundation (RWJF) grant. The purpose of the grant was to study processes and practices within the state and provider systems that were barriers to the use of evidence-based practices (EBP), and consequently improve those practices to increase the utilization of EBP. The focus of the first project year was the development and implementation of medication-assisted services to treat alcohol dependence. The focus in the second year was increased utilization of motivational interviewing. Walk-through exercises were conducted at the provider and state levels during the implementation planning stage. The ability to provide brief motivational interviewing interventions before completion of the assessment was first started with the grant-participating agencies, but was later expanded to all Primary Recovery Plus providers. Nearly all agencies, grant-participating or not, have made efforts to incorporate what was learned during the grant to their current practices.

In mid-to-late FY 2009, the Division added more options to the continuum of care, based in part on lessons learned in the RWJF grant. The Division created a service category available to all contracted programs "ADA Early Intervention Services," that

allows services consistent with Level 0.5 ASAM early intervention criteria to be provided and reimbursed by DMH/ADA within existing provider allocations. The ADA Early Intervention Services program provides for evaluation, education, and early intervention services for individuals with problems or risk factors related to substance use, but for whom an immediate substance-related disorder cannot be confirmed or immediate admission to clinical treatment is not warranted. The program is intended to offer flexibility to providers in determining the appropriate level of services or course of action when a consumer first presents to the agency and exact treatment needs are not yet known. This first encounter should focus on the consumer and his/her needs vs. whether they will be admitted for treatment.

Services currently available in the ADA Early Intervention program include Behavioral Health Consultation with Report (BHCR) and Motivational Interviewing (MI). BHCR is a face-to-face service utilized to determine whether a substance use problem exists and recommend an appropriate course of action, if applicable. It is not intended to be a routine precursor to clinical treatment. Situations when it is appropriately administered include referrals from Probation and Parole, courts, schools, and other agencies when a written report of findings from a substance abuse professional is needed. MI is a face-to-face service to enhance consumer motivation, establish a therapeutic partnership, and increase engagement in treatment. MI, as a distinct service in this context, *may* be delivered sequentially with BHCR.

In FY 2009, Missouri implemented its Missouri Screening, Brief Intervention, and Referral to Treatment (SBIRT) program which is funded by a five year grant from the Substance Abuse and Mental Health Services Administration. There is an emerging body of research and clinical experience that supports the use of the SBIRT model as a set of effective interventions for persons at risk. Missouri sites include Burrell Cox North Emergency Room in Springfield, Missouri; University of Missouri's Hospital Emergency Room and Student Health Center in Columbia, Missouri; Smiley Lane Clinic and Family Health Care Center in Columbia, Missouri; and Grace Hill and Neighborhood Clinics in St. Louis, Missouri.

Recovery Supports

In FY 2009, recovery support services were funded through the federal Access to Recovery (ATR) II grant. Recovery support services included care coordination, child care, emergency housing, family engagement, pastoral counseling, recovery mentoring, transportation, and work preparation. For individuals who needed both treatment and recovery support services, their treatment services were funded through a combination of ATR II, Substance Abuse Prevention and Treatment (SAPT) Block Grant, and state general revenue. In this sense, funding sources were leveraged to provide a continuum of care. In FY 2009, a total of 4,806 individuals received a combination of clinical treatment and recovery support services.

Goal #2: Providing Primary Prevention services

An agreement to spend not less than 20 percent of the SAPT Block Grant on a broad array of primary prevention strategies directed **at individuals not identified to be in need of treatment**. Comprehensive primary prevention programs should include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse.

Specify the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C.§300x-22(a)(1) and 45 C.F.R. §96.124(b)(1)).

Primary Prevention: Six (6) Strategies

• **Information Dissemination** – This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.

• **Education** –This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy.

• **Alternatives** –This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities, and to discourage the use of alcohol and drugs through these activities.

• **Problem Identification and Referral** –This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

• **Community-based Process** –This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.

• **Environmental** –This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population.

Institute of Medicine Classification: Universal, Selective and Indicated:

o ***Universal:*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
o ***Universal Direct. Row 1*** —Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)

o ***Universal Indirect. Row 2***—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
o ***Selective:*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
o ***Indicated:*** Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. *(Adapted from The Institute of Medicine Model of Prevention)*

• *Note:* In addressing this narrative the State may want to discuss activities or initiatives related to: *Disseminating information to stakeholders; Providing education; Providing training/TA Discussing environmental strategies; Identifying problems and/or making referrals; Providing alternative activities; Developing and/or maintaining sub-state contracts; Developing and/or disseminating promotional materials; Holding community forums/coalitions; Using or maintaining a management information system (MIS); Activities with advisory council, collaboration with State Incentive Grant (SIG) project; Delivering presentations; Data collection and/or analysis; Toll-free help/phone line provision; Procuring prevention services through competitive Request for Proposals (RFPs); Site monitoring visits*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

Universal

The Missouri Division of Alcohol and Drug Abuse (ADA) utilizes Universal prevention strategies to address Missouri's entire population (state, local community, school, neighborhood) with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. Missouri's ADA Universal prevention programs continued to focus on the mission of universal prevention, to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem (NIDA 1997).

Universal Direct

During the year, ADA procured with 11 Regional Support Centers (RSCs) to provide ongoing technical assistance to 164 community coalitions comprised of a diverse representation of the community. The coalitions were located throughout the state and represented approximately 1,640 local volunteers present in most of Missouri's 114 counties plus the city of St Louis. The ongoing technical assistance to the community coalitions supported capacity building at the local level through community needs assessments, resource identification, development of community plans to address the identified needs, implementation of plans, and assistance with the evaluation of data for outcomes. In addition, the RSCs provided technical assistance to 18 of the 20 Strategic Prevention Framework State Incentive Grant (SPFSIG) coalitions. The technical assistance provided by the RSCs increased the coalitions' information and skills necessary to prevent substance abuse in their community.

ADA and the Missouri Department of Elementary and Secondary Education (DESE) continued to plan for the Missouri Student Survey (MSS). The MSS is jointly administered by ADA and DESE to assess substance use and related behaviors among 6^{th}-12^{th} graders attending public school across the state. The RSC's use data from the MSS for the community needs assessment.

Partners in Prevention (PIP), Missouri's higher education substance abuse consortium, represented 13 public universities located throughout the state. PIP received the 2009 Community Anti-Drug Coalitions of America (CADCA) Got Outcomes! Coalition of Excellence Award. This award is given to coalitions that have successfully fought substance abuse in their communities through implementation of a strategy or set of comprehensive strategies resulting in measurable change. During FY 2009, an estimated 130,000 students attended PIP campuses full-time. PIP administered the Missouri College Student Health Behavior Survey (MCHBS) to over 6,000 students. Results from the survey showed a reduction in the percentage of PIP students who engaged in binge drinking.

Universal Indirect

During FY 2009, ADA procured with multiple prevention providers for universal indirect services to support population-based prevention and environmental strategies. Three Regional Alcohol and Drug Awareness Resource (RADAR) network sites located in Jefferson City, Kansas City, and St. Louis responded to requests for prevention materials throughout the state. In addition the eleven Regional Support Centers (RSC), the Statewide Training and Resource Center (STRC), the University of Missouri, and 164 local coalitions also provided universal indirect services. The broadcast media was utilized and reached four million individuals aged 5-64 years. KidsCast, a radio and web-based program was available for Missouri youth in 4^{th}-6^{th} grades to increase awareness of how tobacco, alcohol, drug use and unhealthy behaviors impact communities. The KidsCast web-site had over 5,000 page reviews. The 164 Missouri registered coalitions recognized national prevention awareness programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3D Month, and Alcohol Awareness Month.

ADA utilized the Statewide Training and Resource Center (STRC) to provide information, technical assistance, and training to the substance abuse prevention workforce who included ADA and the contractual prevention staff. The STRC, a Community Anti-drug Coalitions of America (CADCA) member, represented Missouri at national conferences. Under the direction of ADA, the STRC administered training, development and consultant funds to the approximately 162 coalitions. These resources were supported with the Governor's Discretionary Fund of Safe and Drug Free School and Communities funds.

Merchant tobacco materials were developed and distributed to the RSCs during the annual merchant education campaign held from February through May, 2008. During the campaign, the RSCs informed retailers on the tobacco laws and on the availability of tobacco retailer training for employees. The campaign consisted of a phone call and two walk-in visits to the state's approximate 6,500 retailer outlets. More than 20,000 phone call and walk-in contacts were completed. Several support centers partnered with the Division of Alcohol & Tobacco Control to provide training to retailers in their region.

ADA continued to support the Missouri Youth/Adult Alliance (MYAA), a statewide coalition that provides resource materials and education to local community efforts focused on addressing underage drinking. MYAA addressed the topics of environmental and social policy change during the annual Speak Hard workshop for youth held in Jefferson City.

Selective

Selective prevention strategies targeted subsets of Missouri's population that were identified by ADA to be at risk for substance abuse. ADA's selective prevention programs were provided through subgroups which as a whole had higher risk of substance abuse than the general population.

ADA implemented selective services through a school-based program, School-based Prevention, Intervention and Resources Initiative (SPIRIT). CSAP model programs were implemented in five school districts: Knox County, Carthage, Hickman Mills, New Madrid, and Ritenour. The school districts participating in SPIRIT were identified as high-risk districts based on the number of youth for each district, the number of referrals to juvenile authorities, school drop-out rates, and the number of students receiving reduced or free lunches. The programs included Peace Builders, Second Step, Project Towards No Drug Abuse, Life Skills and Too Good For Drugs. During 2008, the SPIRIT initiative provided CSAP model programs to over 7,300 students in grades K-9.

Selective prevention services were also provided through eight community-based agencies located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern Missouri known as the Missouri Bootheel. The subgroups targeted by these community-based agencies include youth experiencing academic failure located in communities identified as low income. The evidence-based programs and strategies implemented by these agencies include Creating Lasting Connections, Creating Lasting Family Connections (ages 9-17), Passport to the Future: Urban Rhythms (ages 5-18), Too Good For Drugs (ages 11-14), after school mentoring emphasizing bullying prevention (ages 12-14), Life Skills (ages 12-14), faith-based programs specializing in youth substance abuse prevention (ages 12-18), Promoting Responsibility through Education and Preparation (PREP) mentoring program (ages 9-11), Lincoln University Youth Development Kid's Beat (ages 6-18), All Stars (ages 11-14), and How to Cope (ages 18+). Over 60,000 Missourians were served through these eight agencies.

Selective prevention services were provided through the Missouri Alliance of Boys and Girls Club, consisting of 12 Boys and Girls Club sites located throughout the state. The target subgroup for the Missouri Alliance of Boys and Girls Club was youth who may be academically failing and low-income. The sites implemented SMART Moves to over 60,000 youth ages 5-18.

ADA also provided selective prevention through the Leadership Education and Advocacy for the Deaf (L.E.A.D.), the statewide provider for Deaf and Hard of Hearing. L.E.A.D. targets the subgroup of Deaf and Hard of Hearing youth in Missouri. L.E.A.D. provided The Teen Institute for the Deaf to over 1,000 youth ages 12-17.

Partners in Prevention (PIP) targets the subgroup of students at risk for underage and binge drinking on college campuses. PIP, consisting of 13 state universities, implemented Community Trials, Brief Alcohol Screening and Intervention for College Students (BASICS), and SMART to over 5,800 students ages 18-24.

References:

National Institute of Drug Abuse (1997). “Drug Abuse Prevention: What Works”, pp. 10-15.

Goal #3: Providing specialized services for pregnant women and women with dependent children

An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish and/or maintain new programs or expand and/or maintain the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, to make available child care while the women are receiving services (See 42 U.S.C. §300x-22(b)(1)(C) and 45 C.F.R. §96.124(c)(e)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prenatal care; Residential treatment services; Case management; Mental health services; Outpatient services; Education Referrals; Training/TA; Primary medical care; Day care/child care services; Assessment; Transportation; Outreach services; Employment services; Post-partum services; Relapse prevention; and Vocational services.*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

The Department of Mental Health, Division of Alcohol and Drug Abuse (ADA) has maintained the delivery of specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services to pregnant women and mothers with dependent children. CSTAR programs allow women and their children to receive multiple levels of care based upon their assessed needs. Specialized Women and Children's CSTAR programs are available in each region of the state, in both rural and urban settings. ADA maintained certification standards that prioritize the treatment of pregnant or postpartum women or women with dependent children. During FY 2009, 291 pregnant women entered treatment upon request at specialized CSTAR program and received prenatal care and referrals in accordance with the requirements in the CSTAR certification standards and contract requirements. However, due to geographical barriers or other issues, pregnant women sometimes receive services at other types of CSTAR programs or Primary Recovery treatment agencies. Pregnant women are a priority population for all contracted treatment providers and services are to be individualized to address the specific needs of those served. In total, 589 pregnant women were admitted to ADA-contracted treatment programs

Nurses are available at each Women and Children's CSTAR agency to assist with medical needs and referrals. Community support workers assist consumers with coordinating social service needs identified during the assessment process. Childcare is provided on-site or the program makes arrangements for child care at licensed facilities. Coordination of care between the CSTAR providers, primary care, and managed care health plans (under Medicaid) is required through an established protocol to ensure pregnant women and their unborn children receive access to the services and supports to meet their individual needs.

The Division developed contract language to more specifically address expectations regarding the admission of priority populations. An amendment for Women and Children's CSTAR programs was issued at the start of FY 2010 that more clearly identified the prenatal and supportive services that must be provided or arranged for to meet SAPT Block Grant requirements. This language is as follows:

The contractor shall comply with the following federal requirements for its Women and Children's CSTAR program:

> *a. The contractor shall provide or arrange for the provision of services specified below for pregnant women, and women with dependent children, including women who are attempting to regain custody of their children:*
>
> > *1) Primary medical care for women, including referral for prenatal care and child care while the women are receiving treatment service;*
> >
> > *2) Primary pediatric care, including immunization, for their children;*

3) Gender specific substance abuse treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, parenting and child care;

4) Therapeutic interventions for children in custody of women in treatment which may include, but are not limited to, addressing their developmental needs and issues of sexual and/or physical abuse or neglect; and

5) Sufficient case management and transportation to ensure women and their children have access to needed services.

All treatment providers had their contracts amended at the start of FY 2010 that clearly designated the Division's priority populations and how their admissions were to be managed. The priority population amendment is as follows:

1. *In accordance with the requirements of the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959), Missouri state statute, and Department priorities, the contractor shall give preference for admission to certain identified populations.*

2. The Department has identified two groups of priority populations for substance abuse treatment:

a. Priority I populations: Priority I populations require immediate admission to detoxification or residential support unless clinically contraindicated. Priority I populations include:

- *Women who are pregnant.*
- *Intravenous (IV) drug users who have injected drugs in the prior 30 days. May be referred for immediate admission to an opioid treatment program, if safe and clinically appropriate.*
- *Civil involuntary commitments. Ninety-six hour commitments must be admitted to detoxification services in PR+ or Enhanced PR+ programs. Thirty-day commitments must be admitted to detoxification or to Level 1 with residential support.*

b. Priority II populations: Priority II populations may require admission to detoxification or residential support when in crisis, but otherwise an appointment must be scheduled to occur within two weeks of first contact, followed by treatment at the appropriate level of care. Priority II populations include:

- *Post-partum women (up to six months after delivery).*
- *Women with dependent children under 13 in their physical care and custody.*
- *Families in the child welfare and TANF systems.*
- *Offenders being released from Department of Corrections'*

institutions.
· Offenders given priority for admission by the Division of Probation and Parole (via referral form and protocol).
· Adolescents and families served through the Children's System of Care.

3. For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.

4. In order to provide immediate admission for priority populations, the contractor understands and agrees that clinically stable consumers may require transfer to a less intensive level of care.

5. The contractor shall refer pregnant women to a Women and Children's CSTAR program unless the contractor's treatment team determines that the individual's needs are best met in the contractor's treatment program, and there is clear justification in the clinical record for such determination.

Contract monitoring has occurred annually through Safety and Basic Assurance Reviews at each agency. The monitoring visit included the Area Treatment Coordinator reviewing the program's practices and the Block Grant Requirement Checklist to ensure compliance with requirements. Certification surveys have occurred on a three-year cycle and included a review to ensure pregnant women and their children are receiving priority admission, prenatal care, and safe and appropriate childcare. During FY 2009, monitoring schedules were maintained.

Programs for Pregnant Women and Women with Dependent Children (formerly Attachment B)

(See 42 U.S.C. §300x-22(b); 45 C.F.R. §96.124(c)(3); and 45 C.F.R. §96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2009; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 9 formerly Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY 2009. In a narrative of **up to two pages**, describe these funded projects.

Title XIX, Part B, Subpart II, of the PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section III.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. §300x-22(b)(1)(C) in spending FY 2009 Block Grant and/or State funds?

3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2009 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

FY 2009 Programs for Pregnant Women and Women with Dependent Children

Treatment for women in the State of Missouri has been enhanced over the past twenty years due, in part, to the support of Block Grant funds. The Missouri Department of Mental Health – Division of Alcohol and Drug Abuse (ADA) has moved from providing treatment for women in gender-integrated programs to creating programs designed specifically for women and their children. There are 12 contracts for Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children. Multiple treatment sites are offered across the state. Two CSTAR programs represent a joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. All of the CSTAR programs provide for licensed daycare services for the children accompanying their mothers to treatment, through the direct operation of daycare services on site or arrangement for daycare services in a community setting. Dependent children accompanying their mothers to treatment receive treatment for physical, emotional and behavioral conditions brought about by their mothers' addictions. In this manner, the mandate of Section 1922(c) in spending FY 2009 Block Grant funds for at least a 5% set aside has been exceeded.

Urban hospitals in St. Louis and Kansas City noted the increase in drug-affected children in the late 1980's. By 1988, the number of impaired infants brought about an organized request for ADA to begin treating pregnant and postpartum women and their children. Concurrently, the CSTAR program was being developed to meet the needs of this specific population, assisting them with recovery in any life domain negatively impacted by substance use. By offering a continuum of care, CSTAR is suited to match the level of treatment to the assessed needs of the woman and her children. This continuum of care is described below.

Continuum of Care Provided

Community-based Primary Treatment:
This is the most structured, intensive level of treatment in the continuum of care. Services are provided five to seven days per week in a trauma-sensitive environment. Services available include: day treatment (in FY 2009 this consisted of group and individual counseling, group education, and structured recovery support activities), community support, family therapy, trauma counseling, co-occurring disorders counseling, medication and professional medical services for medication-assisted treatment, residential support and day care for dependent children. Age-appropriate assessment and codependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Intensive Outpatient Rehabilitation:
This level of treatment is designed for women who have a home environment supportive of recovery or are living in approved housing and present less severe symptoms of substance abuse. Women who have completed a more intensive level of treatment are

transitioned into this level of care to provide opportunities for them to interact within their families and community while continuing to receive an intermediate level of support and treatment. Services are provided on several occasions each week. A minimum of ten hours of therapeutic activities are offered each week. Treatment is provided in a trauma-sensitive environment and consists of a menu of services, including: group counseling and education, individual counseling, community support, family therapy, trauma counseling, co-occurring disorders counseling, professional medical services and medication to support medication-assisted treatment, and day care for dependent children. Age-appropriate assessment and codependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Supported Recovery:
This level of care provides service on a regularly scheduled basis, offering a minimum of three hours of therapeutic activities per week. Women who are assessed as needing less intensive or structured clinical services may begin substance abuse treatment at this level. Alternately, women who have completed a more intensive level of treatment may be transitioned into this level of care to provide opportunities to interact within their families and community while continuing to receive regular reinforcement of treatment and recovery principles. Services and supports are offered to promote recovery across the continuum of care. The frequency of services is determined by the assessed clinical needs of the woman. Treatment is provided in a trauma-sensitive environment and consists of a menu of services, including all of those listed under Community-based Primary Treatment and Intensive Outpatient Rehabilitation.

Specialized Treatment

Specialized CSTAR programs for Women and Children must address therapeutic issues that are relevant and specific to women based upon their individual needs. These issues shall include, but are not limited to parenting, relationships, self-esteem/self-identification, domestic violence, sexuality, health, and spirituality. Group counseling is offered to allow consumers to explore emotional issues and work towards the development of healthy self-image, relationships, and lifestyles. Individual counseling allows for development of individualized treatment goals and further exploration of issues impacting treatment and recovery. Group education is provided on a wide array of topics: drugs, communication skills, anger management, coping with trauma, mental health, and relapse prevention.

Child care is provided at all levels of CSTAR programming for women while they attend treatment sessions. State certification standards require each program to be licensed as a daycare facility for children unless an exception is granted. If the treatment provider cannot offer childcare on-site, services must be arranged through a licensed day care facility. A child therapist must be on staff in each program to assess infants/children and either provide the necessary services or make appropriate referrals for infants/children with special needs. Codependency counseling and family therapy are provided for all persons identified with a need for these services.

Women who are homeless may receive housing assistance from ADA while actively participating in treatment. Supportive housing is available as a bridge to other long-term housing arrangements. Two forms of housing support currently available through the treatment providers are community housing and transitional housing. Community Housing may be available to consumers and their families who are in need of a living arrangement that supports ongoing recovery and community integration. Community Housing may be provided in an individual apartment or single-family home of the consumer's choice that is inspected and approved by the Department. The stipend for community housing can be used to pay rent, initial deposits, utilities and local telephone services. Transitional Housing may be provided to consumers in need of a living arrangement that provides an intermediate level of structure, supervision, and external support for their continued recovery. Transitional Housing is provided in a communal living setting limited to sixteen adult beds, inspected and approved by the Department. Transitional Housing funds provide for room and board and on-site supervision when consumers are present.

All women and children who enter treatment are provided health screenings to identify health deficits or needs for medical intervention. Within the CSTAR programs, registered nurses are on duty to assist mothers and their children to achieve health goals. The nurses offer medical services, referrals, and education for all children and families. Each child is required to have a current physical exam and current immunizations. The community support workers assist the consumers in arranging medical appointments and obtaining transportation. Close associations with local health clinics, hospitals, and doctors enable the provision of prenatal care, immunizations, and other preventive measures to promote the well-being of mothers and their children. All CSTAR programs conduct a communicable diseases risk assessment for all consumers upon admission. Pre- and post-test counseling for HIV/AIDS, sexually transmitted diseases and tuberculosis are available on site or by referral at all CSTAR women's programs. This innovative healthcare provision was a result of the FY 1997 mandate to increase and improve services for women.

In FY 2007, a specialized communication protocol was developed to facilitate communication between primary care physicians (PCP), case managers for the Medicaid managed care plans, Women and Children CSTAR providers, and ADA's Clinical Utilization Review Unit. The protocol provides communication guidelines to address pregnant Medicaid women who need substance abuse treatment services. This will ensure pregnant women and their child will have access to all available treatment and support services that meet their specialized treatment needs. The protocol was continued in FY 2009

Dramatic results have occurred due to the provision of treatment services specifically designed for women. In FY 2009, 6,347 women and children were treated in the CSTAR women and children programs. In FY 2009, 121 of 125 babies born to women in these specialized CSTAR programs were born drug-free. In addition, 93 children were returned to their mother's custody from the Children's Division because their

mothers had regained their ability to manage healthy families and live productive lives. The emotional rewards and cost savings from these program measures alone support the cost-effectiveness of continuing specific substance abuse treatment for women and children. The State is moving towards a standardized, outcome-based system of monitoring consumer improvement in numerous domains. Implementation of evidence-based practices to treat this special needs population and quality improvement are on-going goals.

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), type of care (refer to definitions in Section II.5), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

The capacity of Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs in all three levels are limited by the amount of General Revenue and Medicaid dollars available. However, the residential component at facilities is limited to 16 beds for the primary consumers and 10 beds for children. Housing can be made available for families that are homeless or alienated from their families of origin. All of the women's' facilities have access to supportive housing funds, and therefore can offer additional safe housing options.

Women and children served in FY 2009 at the women's programs are provided by level of care and agency:

Agency	collateral	non-collateral		
		short-term residential	intensive outpatient	non-intensive outpatient
Alternative Opportunities, Inc.	119	248	352	175
BASIC	12	0	293	60
Bridgeway Behavioral Health, Inc.	69	520	258	112
Comprehensive Mental Health Services	78	256	253	130
Family Counseling Center	30	316	300	83
Family Counseling Center of Missouri, Inc.	96	245	181	142
Family Self Help Center	147	228	260	81
Hannibal Council On Alcohol & Drug Abuse	75	267	167	51
New Beginnings Cstar	0	0	353	140
Queen Of Peace Center	199	232	569	333
ReDiscover	281	232	638	210

A list of all women and children's CSTAR programs in Missouri including satellite sites is provided. The list includes the parent agency, site name, I-SATS id, address, region (i.e. sub-state planning area), bed capacity, and amount of funding from the FY 2009 Block Grant award.

Parent	Site	I-SATS ID	Street	City	Zip	Region	Bed Capacity	FY 2009 Block Grant Funding
Alternative Opportunities, Inc.	Alternative Opportunities, Inc.	MO101560	1111 South Glenstone	Springfield	65804	Southwest		$13,929
Alternative Opportunities, Inc.	AO - Carol Jones Recovery Center for Women	MO903879	2411 West Catalpa Street	Springfield	65807	Southwest	16 women; 12 children	$37,043
BASIC	BASIC	MO903788	3026 Locust Street	St. Louis	63103	Eastern		$14,069
BASIC	BASIC - Charlotte Merrits Ottley Transitional Women Center	MO101558	3029 Locust Street	St. Louis	63103	Eastern		$60,803
Bridgeway Behavioral Health, Inc.	Bridgeway Behavioral Health, Inc.	MO100786	1570 S. Main St.	St. Charles	63303	Eastern		$24,880
Bridgeway Behavioral Health, Inc.	Bridgeway - St. Charles (Old South River Rd)	MO101136	1601 Old South River Road	St. Charles	63303	Eastern	16 women; 10 children	$38,582
Bridgeway Behavioral Health, Inc.	Bridgeway - Troy (E Cherry)	MO106069	1011 East Cherry Street	Troy	63379	Eastern		$55
Bridgeway Behavioral Health, Inc.	Bridgeway - University City	MO101458	8675 Olive Blvd.	University City	63130	Eastern		$128
Bridgeway Behavioral Health, Inc.	Bridgeway - Warrenton	MO102803	1206 East Veterans Memorial Parkway, Suite A	Warrenton	63383	Eastern		$427
Comprehensive Mental Health Services	Comprehensive Mental Health Services	MO100518	17844 East 23rd Street	Independence	64057	Northwest		$31,857
Comprehensive Mental Health Services	Comprehensive - KC (Swope Pkwy)	MO301678	5840 Swope Parkway	Kansas City	64130	Northwest	16 women; 10 children	$23,584

Parent	Site	I-SATS ID	Street	City	Zip	Region	Bed Capacity	FY 2009 Block Grant Funding
Family Counseling Center of Missouri, Inc.	Family Counseling Center of Missouri, Inc.	MO750056	117 North Garth Ave	Columbia	65203	Central		$20,466
Family Counseling Center of Missouri, Inc.	FCC of MO - Columbia (201 N Garth - McCambridge)	MO902269	201 North Garth Ave	Columbia	65203	Central	16 women; 10 children	$19,258
Family Counseling Center of Missouri, Inc.	FCC of MO - Jefferson City	MO100187	204 Metro Drive, Ste B	Jefferson City	65109	Central		$176
Family Counseling Center, Inc.	Family Counseling Center, Inc.	MO903598	925 HWY VV	Kennett	63857	Southeast		$0*
Family Counseling Center, Inc.	Family Counseling Center - Cape Girardeau	MO101128	20 South Sprigg Street	Cape Girardeau	63703	Southeast	16 residential; can accommodate children	$60,797
Family Counseling Center, Inc.	Family Counseling Center - Hayti (Stapleton Center)	MO301793	501 Highway J	Hayti	63851	Southeast		$20,853
Family Counseling Center, Inc.	Family Counseling Center - Sikeston	MO100649	108 West Center Street	Sikeston	63801	Southeast		$630
Family Self Help Center	Family Self Help Center	MO101029	1809 South Connor Avenue	Joplin	64804	Southwest	16 women; 10 children	$59,112
Family Self Help Center	Family Self Help Center - Neosho	MO100287	118 West Spring Street	Neosho	64850	Southwest		$2,165
Family Self Help Center	Family Self Help Center - Pineville	MO100264	403 Main Street	Pineville	64856	Southwest		$258
Hannibal Council On Alcohol & Drug Abuse	Hannibal Council On Alcohol & Drug Abuse	MO750098	146 Communications Drive	Hannibal	63401	Central	16 women; 10 children	$50,444
New Beginnings Cstar	New Beginnings Cstar	MO102928	3901 North Union Blvd	St. Louis	63115	Eastern		$0**

Parent	Site	I-SATS ID	Street	City	Zip	Region	Bed Capacity	FY 2009 Block Grant Funding
Queen Of Peace Center	Queen Of Peace Center	MO100591	325 N. Newstead Ave	St. Louis	63108	Eastern	16 women; 10 children	$51,088
ReDiscover	ReDiscover	MO100864	901 NE Independence Avenue	Lees Summit	64086	Northwest		$25,140
ReDiscover	ReDiscover - KC (East 117th)	MO104262	6801 East 117th Street	Kansas City	64134	Northwest		$4,431
ReDiscover	Rediscover - KC (East 18th)	MO101207	620 East 18th Street	Kansas City	64108	Northwest	11 women; 6 children (age<12)	$62,279
ReDiscover	ReDiscover - KC (East Armour)	MO101517	301 East Armour Blvd.	Kansas City	64111	Northwest		$29,706

*Parent site is an administrative only site.
**Women's program did not receive FY 2009 Block Grant funds but does receive state funds.

Amounts expended in state FY 2009 by agency on specialized programs for women are as follows:

Provider	Federal Block Grant	State Match	State Non-Match	Total MOE	Federal Medicaid	Total Including Federal Medicaid
Alternative Opportunities	$525,619	$232,773	$397,438	$1,155,830	$397,090	$1,552,920
BASIC	$235,309	$78,844	$336,843	$650,997	$134,660	$785,656
Bridgeway	$478,428	$239,350	$470,589	$1,188,367	$407,624	$1,595,991
Comprehensive	$408,731	$113,852	$448,672	$971,255	$194,254	$1,165,509
FCC Inc	$291,320	$253,235	$607,752	$1,152,308	$431,009	$1,583,317
FCC of MO	$287,304	$134,820	$595,404	$1,017,528	$229,284	$1,246,812
Family Self Help	$363,808	$129,941	$392,731	$886,480	$221,586	$1,108,066
Hannibal Council	$345,613	$84,708	$399,136	$829,457	$144,366	$973,823
Queen of Peace	$178,975	$323,378	$754,188	$1,256,541	$550,445	$1,806,985
Rediscover	$341,106	$208,434	$580,569	$1,130,110	$355,783	$1,485,893
Grand Total	**$3,456,214**	**$1,799,335**	**$4,983,323**	**$10,238,872**	**$3,066,101**	**$13,304,972**

*Total Federal Block Grant expenditures spent in state FY 2009 will not equal total for Form 9, column 5a because Block Grant expenditures spent in state FY 2009 may include expenditures from FY 2007 Block Grant, FY 2008 Block Grant, and FY 2009 Block Grant funds while Form 9, column 5a reports on only FY 2009 Block Grant funds that can be expended over federal FY 2009 and FY 2010. Missouri's state FY 2009 began July 1, 2008 and ended June 30, 2009. Two federal fiscal years will overlap three state fiscal years.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY2009 Block Grant funds?

Treatment services for women in the State of Missouri have continued to expand due in part to the block grant funds. Missouri's Division of Alcohol and Drug Abuse (ADA) moved from providing treatment for women in gender integrated programs to developing

programs designed specifically for women and their children. Twelve provider contracts with multiple treatment site locations have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children in Missouri. Two of the CSTAR programs were designed in collaboration with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. Dependent children were provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction.

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

The specialized programs to meet the needs of pregnant women and women with dependent children are monitored on a regular basis. A site certification survey is conducted at all CSTAR treatment program every three years by a team of treatment certification specialists. The programs are reviewed for compliance with certification standards for CSTAR programs which reflect the accepted standard of care in substance abuse treatment. In addition, Area Treatment Coordinators perform annual Safety and Basic Assurances Reviews (SBARs) which include a review of compliance with Block Grant requirements. The Area Treatment Coordinators also provide technical assistance when necessary. Representatives from each women and children's program meet regularly to collaborate with ADA staff on developing issues and trends.

In addition, continued monitoring of pregnant consumer admissions through the *Substance Abuse Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care* provided the opportunity for ADA staff to work in direct collaboration with the Missouri HealthNet Division (MHD), the state's Medicaid agency, for the purpose of communication and care coordination. The Clinical Utilization Review Unit provided information and education to the CSTAR providers and managed care health plan case managers on the purpose and procedures for implementation of the protocol; in addition to completion of periodic case reviews to ensure pregnant women and their children were receiving access to the resources and supports to meet their individual needs. Clinical Utilization Review staff participated in conference calls with ADA treatment providers, MHD, and the managed care health plans to identify problematic areas in the communication and collaboration process in an effort to improve care coordination efforts. The Clinical Utilization Review unit provided quarterly and year-end reports to MHD on the numbers of pregnant consumers served in ADA treatment programs, as well as identified areas for continued enhancement and improvement of the protocol process.

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

The State uses data reported by the contract providers on a routine basis for monitoring

the treatment capacity and utilization by women. The Department of Mental Health maintains a central data system that identifies, among other data, the services provided, the number of consumers, and consumer demographics (including pregnancy at admission). Requests for treatment by women have increased substantially over the past fifteen years. In 2000, a Placement of Expanded Treatment Services document was developed to assist ADA in placement of new CSTAR Women and Children's programs as funds became available.

5. What did the State do with FY 2009 Block Grant funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

The State of Missouri has been a leader in providing quality substance abuse treatment services to women and their children. ADA has 12 contracts providing CSTAR programs specifically for women at multiple locations. There are an increasing number of women served in state funded programs. The number of women and children treated in Women and Children's CSTAR Programs has increased from 2,548 in FY 1995 to 6,347 in FY 2009.

Goal #4: Services to intravenous drug abusers

An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. §300x-23 and 45 C.F.R. §96.126).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Interim services; Outreach Waiting list(s); Referrals; Methadone maintenance; Compliance reviews; HIV/AIDS testing/education; Outpatient services; Education; Risk reduction; Residential services; Detoxification; and Assessments.*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

The capacity management systems in operation in FY 2009 for the Division of Alcohol and Drug Abuse (ADA) are addressed in certification standards. Relevant standards include:

9 CSR 10-7.030 (1) (Service Delivery Process and Documentation) requires that each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed.

(A) At the individual's first contact with the organization (whether by telephone or face-to-face contact) any emergency or urgent service needs shall be identified and addressed.

1. Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. A person who presents at the program site with emergency service needs shall be seen by a qualified staff member within fifteen (15) minutes of presentation. If emergency service needs are reported by telephone, the program shall initiate face-to-face contact within one (1) hour of telephone contact or shall immediately notify local emergency personnel capable of promptly responding to the report.

2. Urgent service needs are indicated when a person presents a significant impairment in the ability to care for self but does not pose a likelihood of immediate harm to self or others. A person with urgent service needs shall be seen within forty-eight (48) hours, or the program shall provide information about treatment alternatives or community supports where available.

3. Routine service needs are indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. A person with routine service needs should be seen as soon as possible to the extent that resources are available.

(B) The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.

(C) The screening—

1. Shall be conducted by trained staff;

2. Shall be responsive to the individual's request and needs; and

3. Shall include notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community.

The contracts for the Primary Recovery Plus (PR+) programs include specific language informing them that part of the program funding comes from the SAPT Block Grant and is therefore "subject to the federal rules and regulations associated with that grant."

Opioid treatment providers were required to admit or refer individuals who abused intravenous drugs within the past thirty days or were in imminent danger of relapse.

Provider contracts include provisions and requirements related to outreach activities. Additionally, ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim services, including linkage to other appropriate services and community resources, until treatment services at the appropriate intensity are available. Some agencies that are not able to immediately admit to the clinically indicated level of care will engage consumers in orientation and education groups which would address immediate health and safety issues with the aim of reducing adverse health effects of substance abuse and promoting the health of the individual. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. ADA can also assist agencies in locating referral resources throughout the state. Compliance with block grant requirements has been consistently monitored through the certification survey process and annual Safety and Basic Assurance Reviews which includes the Block Grant Requirement Checklist.

The Customer Information Management, Outcomes and Reporting (CIMOR) system, designed and maintained by the Missouri Department of Mental Health, has a waiting list function which can be used in lieu of program enrollment. The functionality of the CIMOR wait list is very limited. In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. That technical assistance occurred in FY 2011. ADA reviewed its processes and procedures for tracking capacity management and admissions of priority populations and developed a proposal and new function in CIMOR to address tracking of capacity management and wait list. This approval occurred on July 21, 2011. The Department of Mental Health CIMOR Steering Committee approved the proposal and is waiting for resources, including programming staff, to complete the CIMOR function. In the interim, ADA is developing a process outside of CIMOR to collect wait list and capacity management information from providers on a weekly basis. The tentative date for providing the instructions and tracking form to providers is May 1, 2012. Since providers will need some time to adjust current processes, the tentative implementation date is July 1, 2012. Implementation of this new data collection process is expected to occur with the roll out of new contract language regarding priority populations and the provision of interim services.

ADA agencies provide a variety of interim services to those waiting for treatment services. Examples of interim services provided directly or via referral include, but are not limited to, the following:

- Case management;
- Medication services;
- Employment services;
- Recovery support services (ATR);
- Education groups;

- Self-help support groups; and
- Medical services.

ADA is in the process of developing new interim service billing codes which will improve the tracking of who receives interim services. The tentative date for implementation of these new codes is scheduled for July 1, 2012.

Programs for Intravenous Drug Users (IVDUs) (formerly Attachment C)

See 42 U.S.C. §300x-23; 45 C.F.R. §96.126; and 45 C.F.R. §96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2009; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. 42 U.S.C. §300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2009 and include the program's I-SATS ID number (See 45 C.F.R. §96.126(a)).

3. 42 U.S.C. §300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. §96.126(b)).

4. 42 U.S.C. §300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. §96.126(e)).

FY 2009 Programs for Intravenous Drug Users (IVDUs)

1. Missouri defines intravenous (IV) drug abusers as those substance abusing persons whose primary, secondary or tertiary route of administration is by needle, whether intravenously, intramuscularly, or subcutaneous injection.

2. Throughout FY 2009, all providers operated at or near capacity. Agencies not at capacity were quickly filled with referrals from waiting lists from other treatment programs. Providers are contractually mandated to adhere to Block Grant requirements. While no official notification of reaching 90% capacity was formally sent to the Division of Alcohol and Drug Abuse (ADA), programs do communicate with staff at the Division's district offices via phone and/or email regarding their capacity when issues arise or when information or referral assistance is requested. At points during which capacity was reached, programs made referrals to other resources in the community, for example, to other contracted providers, private pay opioid, or detoxification programs. The Customer Information, Management, Outcomes and Reporting (CIMOR) information system for the Missouri Department of Mental Health (DMH) has a waiting list function which may be used. ADA has encouraged each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the clinically appropriate level are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those individuals seeking treatment. Compliance with these regulations was monitored by regional staff during site visits using the Block Grant Compliance Checklist during certification surveys and Safety and Basic Assurance Reviews (SBARs). Agency admissions of priority populations, including IV drug users, and management of waiting lists are discussed and monitored during certification and SBAR visits, as well as, during technical assistance visits that might be conducted throughout the year. Regional staff conducting these reviews are knowledgeable about contract requirements and how to apply them to substance abuse treatment programs. Programs demonstrate compliance with capacity requirements by either conducting a brief screening by telephone or in person with the consumer. At that time, an assessment/admission date for individuals requesting service is scheduled or an appropriate referral for alternative or interim services is provided to the consumer.

   The agencies that provided treatment services to IVDUs in FY 2009 are listed as follows:

Organization Name	ISATS ID
Alternative Opportunities, Inc.	MO101560
BASIC	MO903788
Bridgeway Behavioral Health, Inc.	MO100786
Burrell Behavioral Health Care Center	MO902004
Center For Life Solutions, Inc.	MO301603
Clark Community Mental Health Center	MO101631

Organization Name	ISATS ID
Community Mental Health Consultants	MO100930
Community Services of Missouri, Inc.	MO102035
Community Treatment, Inc.	MO901592
Comprehensive Mental Health Services	MO100518
E.S.C.A.P.E. Outpatient Chemical Dependency Center	MO103868
Eastern Mo Alternative Sentencing Services, Inc.	MO101623
Family Counseling Center of Missouri, Inc.	MO750056
Family Counseling Center, Inc.	MO903598
Family Guidance Center	MO101532
Family Self Help Center	MO101029
Gateway Foundation, Inc.	MO101433
Gibson Recovery Center, Inc.	MO101673
Hannibal Council On Alcohol & Drug Abuse	MO750098
Hopewell Center	MO101475
Kansas City Community Center	MO301785
Liberty Programs Inc., The	MO101490
Meramec Recovery Center, Inc.	MO102027
Missouri Alcohol Assessment Consultants	MO101987
New Beginnings CSTAR	MO102928
Northland Dependency Services, LLC	MO101755
Ozark Center	MO903770
Paseo Clinic	MO100667
Pathways Community Behavioral Healthcare, Inc.	MO901527
Phoenix Programs, Inc.	MO102159
Preferred Family Healthcare, Inc.	MO101797
Queen Of Peace Center	MO100591
RDC Grop, Inc. d/b/a Correction Services	MO101482
ReDiscover	MO100864
Salvation Army - Harbor Light Center	MO101033
Samuel U Rodgers Health Center	MO100716
Scott Greening Center For Youth Dependency	MO100922
Sigma House of Springfield	MO750593
Southeast Missouri Behavioral Health, Inc.	MO903259
Swope Health Services	MO106598
Tri-County Mental Health Services	MO105152
Westend Clinic	MO105087

Contract language designates IV drug users as a priority I population for all treatment programs. As a priority I population, IV drug users who have injected drugs in the prior 30 days require immediate admission to detoxification or residential support unless clinically contraindicated. IV drug users may be referred

for immediate admission to an Opioid treatment program if safe and clinically appropriate. Contract language indicates:

a. For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.
b. In order to provide immediate admission for priority populations, the contractor understands and agrees that clinically stable consumers may require transfer to a less intensive level of care.

In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. That technical assistance occurred in FY 2011. ADA reviewed its processes and procedures for tracking capacity management and admissions of priority populations and developed a proposal and function in CIMOR to address tracking of capacity management and waiting lists. This approval occurred on July 21, 2011. The DMH CIMOR Steering Committee approved the proposal and is waiting for resources, including programming staff, to complete the CIMOR function. Implementation date of a new CIMOR wait list and capacity management module is not known but is expected to be after January 2014. In the interim, ADA is developing a process outside of CIMOR to collect wait list and capacity management data on a weekly basis. The tentative date for providing the instructions and tracking form to providers is May 1, 2012. Since providers will need some time to adjust current processes, the tentative implementation date is July 1, 2012. Implementation of this new data collection process is expected to occur with the roll out of new contract language regarding priority populations and the provision of interim services.

3. Opioid treatment providers were required to admit persons, within the Block Grant required time frames, who have used IV drugs within the prior 30 days, are pregnant, have HIV, or who were in imminent danger of relapse. If at capacity, programs were to make referrals to other resources in the community, for example, to private pay opioid programs or detoxification programs. The information system designed and maintained by DMH has waiting list functionality. ADA has encouraged each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the clinically appropriate level are available. As described above, there are proposed changes to the CIMOR system that have been approved. An implementation timeline is not known at present. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those individuals seeking treatment. Compliance with Block Grant regulations was monitored by regional staff during site visits using the Block Grant Compliance Checklist during certification surveys and Safety and Basic Assurances Reviews.

Contract language designates IV drug users as a priority I population for all treatment programs. As a priority I population, IV drug users who have injected drugs in the prior 30 days require immediate admission to detoxification or residential support unless clinically contraindicated. IV drug users may be referred for immediate admission to an Opioid treatment program if safe and clinically appropriate. Contract language indicates:

a. For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.
b. In order to provide immediate admission for priority populations, the contractor understands and agrees that clinically stable consumers may require transfer to a less intensive level of care.

In FY 2009, a new data field was added to the CIMOR information system to capture *Date of First Contact.* In FY 2010, ADA began sending providers monthly summary reports of days waiting for treatment. In addition, the Division developed an on-demand report in CIMOR that allows providers to view days waiting for treatment for admitted consumers.

In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. That technical assistance occurred in FY 2011. ADA reviewed its processes and procedures for tracking capacity management and admissions of priority populations and developed a proposal and function in CIMOR to address tracking of capacity management. This approval occurred July 21, 2011. The Department of Mental Health CIMOR Steering Committee approved the proposal and is waiting for resources, including programming staff, to complete the CIMOR function.

4. ADA has encouraged certified substance abuse treatment providers to conduct outreach services to consumers needing treatment to address intravenous (IV) drug use. Outreach requirements were specified in provider contracts. As outreach services are billable, documentation is required to reflect the description of the outreach activity. Contract language specifies:

    a. The contractor may provide clinical outreach services for certain persons including individuals using intravenous drugs. For IVDUs, outreach activities are to promote their engagement in substance abuse treatment.
    b. Clinical Outreach activities may include assessment, consultation, coordination, and referral.
    c. Clinical outreach services shall be provided on a face-to-face basis.
    d. The contractor shall maintain a log for clinical outreach service provided that includes, at a minimum, the following information:
        i. Date of service
        ii. Actual time
        iii. Name of consumer/person

iv. Referral source
v. Name and title of staff providing the services
vi. Description of the outreach activity; and
vii. Outcome or disposition.

e. Contractor staff providing this service shall be qualified substance abuse professionals or community support workers, as defined in certification standards.

Specific examples of outreach activities and efforts (billable and non-billable) include the following:

- liaison programs with local hospitals wherein treatment program staff help facilitate appropriate medical services for pregnant IVDUs or users of other opioids, as well as offer postpartum courses for the mothers' continued stability;
- referral relationships with local methadone clinics;
- education of referral sources (Department of Corrections, hospitals, psychiatric units, health departments, physicians) regarding issues specific to IVDUs and the prioritization of their treatment needs;
- use of motivational interviewing techniques when communicating with IVDUs;
- education offered to co-collaborators of regional social initiatives; and,
- identification of this target population through screenings with the Screening Brief Intervention Referral to Treatment (SBIRT) project.

Contract compliance is one of the areas monitored by regional staff during Safety and Basic Assurance Reviews (SBARs). Providers are encouraged during certification surveys to engage consumers' families in treatment and to address family IV drug use. ADA collaborates with treatment providers and the Missouri Department of Health and Senior Services (DHSS) to present blood-borne disease prevention information to consumers and to utilize appropriate HIV and Hepatitis screening tools during consumer admission to treatment. Additionally, ADA collaborates with treatment providers, DHSS and the Missouri Department of Corrections to educate consumers about treatment options for intravenous drug abuse. Individual providers offer presentations specific to IV drug use to local probation, parole, drug, and mental health courts personnel.

Program Compliance Monitoring (formerly Attachment D)

(See 45 C.F.R. §96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of Title XIX, Part B, Subpart II of the PHS Act: 42 U.S.C. §300x-23(a); 42 U.S.C. §300x-24(a); and 42 U.S.C. §300x-27(b).

For the fiscal year two years prior (FY 2010) to the fiscal year for which the State is applying for funds:

In **up to three pages** provide the following:

• A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and

• A description of the problems identified and corrective actions taken:

1. **Notification of Reaching Capacity** 42 U.S.C. §300x-23(a)
(See 45 C.F.R. §96.126(f) and 45 C.F.R. §96.122(f)(3)(vii));
2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)
(See 45 C.F.R. §96.127(b) and 45 C.F.R. §96.122(f)(3)(vii)); and
3. **Treatment Services for Pregnant Women** 42 U.S.C. §300x-27(b)
(See 45 C.F.R. §96.131(f) and 45 C.F.R. §96.122(f)(3)(vii)).

FY 2010 Program Compliance Monitoring

1. Notification of Reaching Capacity

All contracted substance abuse treatment agencies in Missouri's publicly-funded system of care continue to remain at or near capacity. Regional monitoring procedures are in place to assist consumers in accessing treatment as quickly as possible. ADA has a toll-free number advertised to consumers for providing treatment referrals. Regional staff receive the calls and make referrals to treatment programs in the consumer's area. Agency activity levels are monitored at the regional level through the Regional District Administrators and Area Treatment Coordinators (ATCs). Regional District Administrators and ATCs meet with providers on an as-needed basis to discuss issues pertaining to access, capacity, referral processes, and other treatment issues. As noted, ATCs and District Administrators regularly take calls from consumers attempting to access care at local providers. As consumers are assisted with obtaining a referral, regional ADA staff obtain real-time feedback about capacity and access issues at the providers in their regions. ATCs also conduct yearly Safety and Basic Assurance Reviews at each provider in their respective regions. Every three years, the ADA Certification team conducts comprehensive surveys. Compliance with certification standards is assessed. While always an issue of importance, the Division of ADA is beginning to focus very specifically on how agencies provide a continuum of care to consumers. This includes how the agency provides for all levels of care needed and/or how the agency works with other agencies to provide a full range of services at varying intensities.

Agencies within close proximity of each other have also developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. In addition, ADA assists agencies in locating treatment services throughout the state. Again, assessing a provider's capacity to provide or arrange for a full continuum of care will assist in monitoring for access and capacity issues.

The Customer Information Management, Outcomes, and Reporting (CIMOR) system, designed and maintained by the Missouri Department of Mental Health (DMH), provides a wait list function. CIMOR is accessible to all the organizations that have contracts with the Division of Alcohol and Drug Abuse (ADA). ADA encourages each provider to maintain contact with those consumers on their waiting lists by providing interim treatment services until services at the appropriate level of care are available and/or providing referrals for adjunct or supportive services.

In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. A technical assistance site visit occurred in August 2010. That site visit included a review of current policies, procedures, information system functionality, Block Grant statutory requirements, and strategies for collecting capacity management and wait list data. The visit included a conference call with service providers to gain

perspective from the provider level given their policies, procedures, and day-to-day operations. ADA convened a capacity management workgroup which included staff from the treatment, fiscal, and research units and information technology staff to develop recommendations for capacity management and wait list. The group met regularly over the course of eight months. In May 2011, a proposal to add a new capacity management screen to the CIMOR information system was finalized. This new screen will capture capacity and census data by type of program, modality, gender status, and level of care. The finalized proposal was submitted to the CIMOR steering committee for their review and approval. That approval was granted in late spring 2011. The capacity management project is now on the list for CIMOR development.

2. Tuberculosis Services

ADA collaborates with the Missouri Department of Health and Senior Services (DHSS) to access current information and training information related to the prevention and treatment of tuberculosis in high risk groups. ADA requires contracted treatment providers to maintain referral relationships with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. The services provided include educational information about tuberculosis, related health risks and risks of transmission. Also, tuberculosis testing services are provided to determine whether the individual has been infected with mycobacterial tuberculosis. Those testing positive receive referral for appropriate medical evaluation and treatment.

All contacted substance abuse treatment facilities are required by contract to provide access to tuberculosis testing. Some facilities provide testing on site while others refer consumers to the county health department. The treatment facilities are required to maintain collaborative relationships with their county health departments. Consumers may have access to testing and health care services at any time during their treatment. Agencies may not deny access to treatment based on a positive tuberculosis test result providing the individual does not have active disease. Treatment providers are required by contract to make appropriate referrals for persons seeking services who are not admitted to their program. Treatment providers may request assistance from county health department staff to observe their consumers taking preventive medicine when a positive tuberculosis skin test is identified.

The Area Treatment Coordinator or a treatment specialist from ADA is available to assist if an agency has difficulty finding services or has concerns about referring someone with positive tuberculosis test results. ADA staff may assess the needs of the consumer, advise agency staff of procedures and protocols or, if necessary, seek assistance from the DHSS, Bureau of Tuberculosis Control, in determining appropriate services and available medical resources.

The Division's treatment specialists, District Administrators, and Area Treatment Coordinators continue to work with treatment providers and county health departments to maintain and improve tuberculosis services. Through site certification surveys, Safety and Basic Assurances Reviews, and technical assistance visits, ADA monitors

tuberculosis services including screening, referral, testing procedure, counseling, and consumer confidentiality. Certification surveys are conducted every three years. Safety and Basic Assurance Reviews are conducted during the years in which certification is not performed. Technical assistance visits are provided as needed. Providers' billings of pre- and post-test counseling services can be determined through CIMOR and associated reporting programs.

The infection control recommendations and protocols for substance abuse treatment providers include, but are not limited to, the following procedures:

- screening of patients,
- identifying those individuals who are at high risk of becoming infected, and
- complying with all state reporting requirements while adhering to federal and state confidentiality requirements.

No problems related to tuberculosis services were identified and thus, no corrective action was taken.

3. Treatment Services for Pregnant Women

It has been a long-standing Division of Alcohol and Drug Abuse (ADA) policy that service providers must give priority to pregnant women seeking admission to treatment. Certification standards mandate this for programs specializing in women's treatment. ADA maintains the delivery of specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services to pregnant women and mothers with dependent children. Missouri continues to offer these services to women and children suffering from the effects of substance abuse. CSTAR programs allow women and their children to receive multiple levels of care depending on assessed need. These programs are available in each region of the state. ADA has maintained certification standards which establish substance abusing pregnant or postpartum women or women with custody of children as a first priority population. CSTAR certification standards (9 CSR 30-3.190 Specialized Program for Women and Children) state that "[p]riority shall be given to women who are pregnant or postpartum" and, "[t]he program shall engage in all activities necessary to ensure the actual admission of and services to those women who meet priority criteria."

To further ensure all treatment programs understand the prioritization of pregnant women, new contract language in FY 2010 clearly identifies pregnant women as a treatment population for whom admission must be immediate. To further specify block grant requirements for those programs specializing in the treatment of women, a contract amendment was issued that outlines the services that must be provided or arranged for pregnant women and women with dependent children.

During FY 2010, 626 pregnant women entered Missouri's substance abuse treatment system upon request and received prenatal care and referrals in accordance with the

requirements certification standards and contracts. In FY 2011, there were 622 pregnant women were admitted to substance abuse treatment services.

Contract monitoring occurs annually through Safety and Basic Assurances Reviews at the program site. This review includes the Area Treatment Coordinator reviewing the program's practices and Block Grant Requirement Checklist to ensure compliance. Certification surveys occur on a three-year cycle and include a review to ensure pregnant women are receiving first priority for services, pregnant women are receiving prenatal care, and children are receiving safe and appropriate childcare. Monitoring schedules are current, and programs are in compliance.

Additionally, for those pregnant women under Medicaid manage care, monitoring occurred through an established protocol which is intended to facilitate communication between the ADA treatment provider, MO HealthNet managed care case manager, and the primary care physician for the purpose of care coordination. The protocol prompts providers to alert the managed care case manager and primary care physician upon discovery of a pregnant consumer enrolled in ADA treatment services. These parties are then to coordinate care to optimize the probability of a drug-free birth and to support the woman's entry into long-term recovery.

As no problems were noted, no corrective actions were taken.

Goal #5: TB Services

An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. §300x-24(a) and 45 C.F.R. §96.127).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Compliance monitoring: Referrals; Screening; PPD or Mantoux Skin tests; Provider contracts; Site visits/reviews; Assessments; Counseling; Training/TA; Cooperative agreements; Case management; Wait lists; Promotional materials*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

The Department of Health and Senior Services (DHSS) serves as a repository for statistical data and as an information and training resource related to tuberculosis (TB) issues. There is a Memorandum of Understanding between the Division of Alcohol and Drug Abuse (ADA) and DHSS with the purpose of combining "skills, experience, and expertise for the development of a collaborative educational effort designed to benefit the general public and those at high risk for health and mental health conditions." The Memorandum was modified from a yearly agreement and was extended to five years. This collaborative effort is to provide for an integrated systems framework by which both entities will educate, through technical assistance, local providers contracted with ADA to provide substance abuse counseling services, in order to better serve the consumers. ADA has a representative who has attended Community Planning Group meetings that address a variety of issues related to communicable diseases. The ADA representative has disseminated information to providers as it relates to TB services, information, and issues. ADA participation in Community Planning meetings continued with collaboration as to the risk of substance abuse and risk behaviors of the gay, lesbian, bisexual, and transgender communities of Missouri. The DHSS continues to provide follow-up diagnostic services for consumers who do not have health care resources. The DHSS has demonstrated their commitment to the provision of consistent TB services at the community level. This state department serves as a repository for statistical data and as an information and training resource related to tuberculosis issues.

ADA has required contracted treatment providers to make TB skin testing available to all consumers in their programs. Health screening is a best practice utilized upon admission and thereafter during treatment, as needed, to identify those consumers who might be considered at risk for transmitting *M. tuberculosis* or who might be infected. Consumers may request TB testing and/or counseling. Treatment providers are also required to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. This requirement was and is formalized, along with requirements for other communicable diseases, in contract language as follows:

> ***Communicable Diseases Risk Assessment, Education, Testing and Counseling***
>
> *1. The contractor shall have a working relationship with the local health department, physician, or other qualified healthcare provider in the community to provide any necessary testing services for Human Immunodeficiency Virus (HIV), tuberculosis (TB), sexually transmitted diseases (STDs), and Hepatitis.*
>
> *a. The contractor shall arrange for HIV, TB, STDs and Hepatitis testing to be available to the consumer at any time during the course of the consumer's treatment.*
>
> *1) The contractor shall make referrals and cooperate with appropriate entities to ensure coordinated treatment, as*

appropriate, is provided for any consumers with positive tests.

2. *The contractor shall provide or arrange individual counseling for consumers prior to testing for HIV.*

    a. *In the event the contractor elects to provide HIV pre-test counseling, counseling shall be provided in accordance with the State of Missouri Department of Health and Senior Services (DHSS) Rule (19 CSR 20-26.030), as mandated by state law. These requirements may be downloaded from the following site:*

    http://www.sos.mo.gov/adrules/csr/current/19csr/19c20-26.pdf

    b. *Contractor staff providing HIV pre-test counseling must be trained in accordance with DHSS requirements. The contractor shall be responsible for all costs associated with receiving any such training.*

3. *The contractor shall provide or arrange individual post-test counseling for consumers who test positive for HIV or TB.*

    a. *Contractor staff providing post-test counseling must be knowledgeable about additional services and care coordination available through the DHSS.*

4. *The contractor shall arrange and coordinate, as necessary, post-test follow-up for consumers who test positive for STDs or Hepatitis.*

5. *The contractor shall provide group education with substance abusers and/or significant others of abusers to discuss risk reduction and the myths and facts about HIV/TB/STD/Hepatitis and the risk factors for contracting these disease.*

Compliance with TB and other communicable disease-related requirements was and is assessed as part of annual Safety and Basic Assurance Reviews (SBARs), at certification surveys, and at accreditation surveys for Missouri's Opioid treatment programs. This requirement is specifically included on the tool used to conduct SBARs. The SBAR process involves interviewing provider staff about these requirements and discussing established community linkages. As screening for communicable diseases is a requirement of intake assessments, information about one's risk status can be found in chart reviews during both SBARs and certification visits. Information is also screened by ADA through clinical reviews that are electronically processed through the Department of Mental Health's Customer Information Management Outcomes and Reporting (CIMOR) system. Chart reviews focus on how a consumer has been provided, or has had access arranged for, a full continuum of care, including medical and health-related services.

The ADA representative met with DHSS' TB Coordinator to review the Center for Disease Control's (CDC) "Guidelines and Recommendations for Preventing the Transmission of *M. tuberculosis* in HealthCare Settings." This review analyzed the risk level of and needed precautions for substance abuse treatment settings and staff at the

facilities. ADA standards and ADA contract language with providers were sufficient to meet the guidelines and recommendations of the CDC publication.

Goal #6: HIV Services

An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. §300x-24(b) and 45 C.F.R. §96.128).

Note: If the State is or was for the reporting periods listed a designated State, in addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *HIV testing; Counseling; Provider contracts; Training/TA Education; Screening/assessment; Site visits/reviews; Rapid HIV testing; Referral; Case management; Risk reduction; and HIV-related data collection*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

Missouri was not a designated state.

Tuberculosis (TB) and Early Intervention Services for HIV (formerly Attachment E)

(See 45 C.F.R. §96.122(f)(1)(x))

For the fiscal year three years prior (FY 2009; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended for tuberculosis services. If a "designated State," provide funds expended for early intervention services for HIV. Please refer to the FY 2009 Uniform Application, Section III.4, FY 2009 Intended Use Plan (Form 11), and Appendix A, List of HIV Designated States, to confirm applicable percentage and required amount of SAPT Block Grant funds expended for early intervention services for HIV.

Examples of **procedures** include, but are not limited to:

• development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
• the role of the Single State Agency (SSA) for substance abuse prevention and treatment; and
• the role of the Single State Agency for public health and communicable diseases.

Examples of **activities** include, but are not limited to:

• the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
• the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
• the linkages between IVDU outreach (See 42 U.S.C. §300x-23(b) and 45 C.F.R. §96.126(e)) and the projects delivering early intervention services for HIV; and
• technical assistance.

Attachment E

Note: Missouri is not an HIV designated state.

The Division of Alcohol and Drug Abuse (ADA) has provided tuberculosis (TB) and human immunodeficiency virus (HIV) services in the four publicly-funded methadone programs and other selected treatment programs since 1989. Linkages between early intervention services for HIV and the Intravenous Drug Users (IVDU) Outreach Programs included methadone service providers as well as other identified efforts, particularly in St. Louis and Kansas City.

Since July 1, 1993, all substance abuse treatment programs have provided TB and HIV services to consumers entering treatment by arranging with a nearby health clinic to provide consumers with TB testing and counseling. Testing and other services are provided by the local health clinic with a referral from the substance abuse treatment program. In FY 2009 $39,298 of total state funds and $9,592 of federal funds were spent on TB services for clients who were in substance abuse treatment – for total TB expenditures of $48,890.

During FY 2009 $489 was spent on TB tests by Department of Health and Senior Services (DHSS). All consumers, whether admitted or not, are offered the service. Follow-up counseling and ongoing services are then provided collaboratively between the substance abuse provider and the health clinic. An ADA Treatment Specialist coordinates the HIV and TB services with the DHSS, local county health departments, and substance abuse programs to ensure services are available to all consumers.

In FY 2009 these services and local linkages between substance abuse programs and local clinics were evenly distributed statewide and involved all contracted program sites. All consumers received a HIV/STD/TB/Hepatitis Risk Assessment at admission to treatment and appropriate referrals were made. Pre-and post-test counseling, testing, and HIV education were available to consumers in substance abuse treatment. A total of $31,628 was spent on TB pre-and post-test counseling.

A Treatment Specialist from ADA maintained regular contact with contracted agencies and coordinated technical assistance education. A qualified contracted provider conducted regional trainings for treatment providers regarding HIV Prevention and Pre/Post Test Counseling. Additional services were provided by the Department of Mental Health in the form of technical assistance and consultation. ADA adhered to the protocols established by the Centers for Disease Control and Prevention (CDC) and DHSS.

All offenders receiving substance abuse treatment within the Missouri Department of Corrections (DOC) receive TB testing with a two-step test at intake. This is performed and read by licensed nurses. Patient education is also provided. Testing is performed annually in the birth month or if a consumer is symptomatic or is exposed to an active case. Those who are symptomatic or have positive tests/x-rays/sputum are isolated in

respiratory isolation. They remain there until TB is ruled out or until treatment is proven successful by negative sputum tests. Those with a positive test, indicating exposure, but without active disease, are given prophylactic treatment directly observed by nursing staff. Those with active disease are given medication and housed in respiratory isolation until no longer contagious. Those exposed to active cases are tested. All positive tests are reported to DHSS. If an active case is identified DOC works with the DHSS to develop an action plan. A total of $7,181 was spent by DOC on the above TB services.

The responsibility for public health and communicable diseases is a secondary role for the Division, but requires close coordination of policy and program priorities between DHSS and ADA. ADA has a current Memorandum of Understanding (MOU) with DHSS which identifies the on-going partnership related to the prevention of communicable disease. This MOU identifies that ADA will continue to collaborate with DHSS to strengthen community access to, and utilization of, HIV prevention and care services, sexually transmitted diseases (STD), Hepatitis, and TB educational, screening, and treatment services. Continued technical assistance and regional cross-training are available for delivery to all regions in the state as identified in the current MOU between DHSS and ADA.

Goal #7: Development of Group Homes

An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. §300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

Note: If this goal is no longer applicable because the project was discontinued, please indicate.

If the loan fund is continuing to be used, please indicate and discuss distribution of loan applications; training/TA to group homes; loan payment collections; Opening of new properties; Loans paid off in full; and loans identified as in default.

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

From 2002 to June 2010, the state of Missouri contracted with Oxford House, Inc. to manage the Revolving Loan Fund to provide start-up costs for safe, stable housing for individuals in recovery. To be accepted in an Oxford House, the individual in recovery completed and submitted an application to a House. Members of the House reviewed the applications, interviewed applicants, and determined through a democratic vote who to accept into the House. House members were required to maintain sobriety. A return to substance use resulted in automatic expulsion. Individuals accepted into an Oxford House were required to attend self-help groups such as AA during the first 30 days of acceptance and were encouraged to attend on a regular basis thereafter. In addition, individuals accepted into an Oxford House were required to obtain employment within 30 days of acceptance if not already employed or on disability. If the individual was on disability, the individual was required to be attending school or engaging in at least 20 hours of community service per week.

Each house elected officers that generally included a president, treasurer, secretary, comptroller, and coordinator. The treasurer and comptroller were responsible for the House's money management. Regular House meetings were held to discuss the House's financial status as well as other issues impacting the House and its members. Each House member was responsible for paying an equal share of the household expenses as well as contributing to the household chores. Household expenses included rent for the House and utilities. The lease for the House was established between the landlord and the House members. The Division of Alcohol and Drug Abuse's (ADA) housing specialist worked to educate landlords on the Oxford House program and to find landlords willing to rent their property as an Oxford House.

The Oxford Houses formed chapters. The state's 54 Oxford Houses in operation in FY 2009 were represented by 6 chapters. The chapters engaged in public relations activities to inform individuals and groups about the Oxford House program. This included monthly presentations at substance abuse treatment centers to individuals who may be in need of stable housing once treatment has been completed. The chapters also met to discuss issues faced by member Houses. The ADA housing specialist provided consultation to chapters and individual houses on various issues including, but not limited to, financial management and relationship issues – making referrals as needed. In addition, the ADA housing specialist worked with Houses to attract new members to fill vacancies. It was not uncommon, however, for Houses to have waiting lists. The ADA housing specialist received and monitored regular loan payment reports from Oxford House, Inc. Technical assistance from the ADA Drug Free Group Home Specialist was provided to Houses falling behind in their financial commitments.

In FY 2009, Missouri had 54 Oxford Houses – 41 for men with a total of 336 beds, 12 for women with a total of 98 beds, and 1 house for veterans with a total of 8 beds. Most of the state's Oxford Houses were located in cities of sufficient size to support the needed membership. This included the Kansas City area in the Western part of the state, the St Louis area in the Eastern part of the state, Columbia in the Central part of

the state, and Springfield in the Southwestern part of the state. Some Houses were also located in smaller towns including Winfield, Joplin, Cape Girardeau, St Joseph, Festus and St. Charles.

At the start of FY 2009, there was $34,000 in the revolving loan account. Six new loans totaling $24,000 and two stabilization loans had been given over FY 2009. New houses that were opened were: Hubbell (10/21/2008), Pioneer Dr (1/26/2009), Chouteau (1/26/2009), Proctor (1/30/2009), S. Pacific (4/22/2009), and South Jefferson (4/22/2009). The houses that received stabilization loans were Elliott and Wall.

As the loans were paid back, more loans were taken out to open new houses. In January 2010, the State contacted Oxford House Inc. to seek an explanation for the revolving loan fund balance being below $100,000 as required by SAPT Block Grant requirements. Oxford House Inc. responded to the Division's inquiry in February 2010. Oxford House Inc. indicated that since inception the Missouri Recovery Home Revolving Loan fund has loaned more than $300,000 to start new Oxford Houses. Over the last seven years repayments have been made by Oxford Houses and the chapters at a rate of 73%. Over the last several years, the loan has been slow to replenish due to an increase in the number of houses closing.

At the beginning of FY 2011, the Division of Alcohol and Drug Abuse (ADA) terminated its contract with Oxford House, Inc. as the result of dwindling resources at ADA and a deficiency in the revolving loan balance that conflicts with the statutory requirement of at least a $100,000 balance. In the future, ADA will opt out of maintaining group homes through a revolving loan fund. The remaining balance of the revolving loan was re-allocated to fund substance abuse services.

Group Home Entities and Programs (formerly Attachment F)

(See 42 U.S.C. §300x-25)

If the State has chosen in FY 2009 to participate and support the development of group homes for recovering substance abusers through the operation of a revolving loan fund, the following information must be provided.

Provide a list of all entities that have received loans from the revolving fund during FY 2009 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:

• the number and amount of loans made available during the applicable fiscal years;

• the amount available in the fund throughout the fiscal year;

• the source of funds used to establish and maintain the revolving fund;

• the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;

• the private, nonprofit entity selected to manage the fund;

• any written agreement that may exist between the State and the managing entity;

• how the State monitors fund and loan operations; and

• any changes from previous years' operations.

FY 2009 Group Home Entities and Programs

The Anti-Drug Abuse Act of 1988 (Pub. I. 100-690, approved November 18, 1988) amended Subpart I of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x) by adding a new section 1916A establishing a program entitled Group Homes for Recovering Substance Abusers.

Under the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the Missouri Department of Mental Health (DMH) established the Group Home Revolving Loan fund by contract with the Missouri Housing Development Commission (MHDC) effective August 11, 1989. In 2002, the DMH contracted with Oxford House, Inc. to manage the Revolving Loan Fund. States initially were required to establish the revolving fund in the amount of $100,000. States must establish, directly or through the provision of a grant or contract to a non-profit entity, a revolving loan fund.

By law, individual loans for the establishment of programs to provide housing were not to exceed $4,000 each. The loans were to be repaid within a 2 year period. These funds were to be used to provide start-up loans to groups of recovering individuals.

As stipulated in accordance with the specifications in the Block Grant legislation, the loans had specific requirements. An application was to be submitted to the DMH and signed by at least six recovering individuals who have completed alcohol and/or drug treatment. They must want to start a self-run, self-supported alcohol and drug free house. After reviewing the application, the DMH forwarded the application to Oxford House World Services where a review was completed; a check was then forwarded to the applicant (borrower). Loan checks were not made payable to individuals but in the name of the house which was designated by the name of the street or town where it was located. Loan repayment schedules were in 12, 18, or 24 month installments. No loan payments were due for the first 30 days after the original loan was issued. No interest was charged to the borrower on the principal on the loan. Repayments were made to Oxford House World Services where they were deposited into the revolving loan fund. Late payments from the borrower were assessed a 20% or $25 penalty if not received as scheduled.

Six new loans totaling $24,000 and two stabilization loans had been given over FY 2009. New houses that were opened were: Hubbell (10/21/2008), Pioneer Dr (1/26/2009), Chouteau (1/26/2009), Proctor (1/30/2009), S. Pacific (4/22/2009), and South Jefferson (4/22/2009). The houses that received stabilization loans were Elliott and Wall.

The amount of funds available as of July 1, 2009 was $32,632. A monthly report was forwarded by Oxford House World Services giving details for each loan and payment schedule. Every house that had a loan received a payment book and was contacted if scheduled payments was late or had not been received. There were instances of late payments or loan defaults due to vacancies, unexpected increases in utility bills, house closings, or changes in the house such as switching from a women to men's houses. In

FY 2009, 23 loans were outstanding totaling $62,356. Twelve loans were in default totaling $38,270. When payment issues arose, a letter was sent to the house reminding them of their payment obligations. In cases where a house closed, the loan was reassigned to the Oxford House Chapter or another house until the loan was repaid.

On a monthly basis, the Oxford House Drug Free Group Home Specialist received the loan report from Oxford House World Services detailing the activity of every house. Any house experiencing financial difficulty was contacted and counseled by the Drug Free Group Home Specialist who was employed by the Department of Mental Health, Division of Alcohol and Drug Abuse (ADA). Technical assistance was provided by the Drug Free Group Home Specialist and could be obtained through a toll-free phone number. Through publications, meetings, and workshops, ADA made education of the Oxford House concept a priority for legislators, communities, and local government agencies throughout Missouri.

From 2002 to June 30, 2010, 118 loans were committed in Missouri for drug-free group homes. The homes were located in 15 Missouri cities. More than $364,000 was loaned to open Oxford Houses in Missouri since 1989.

At the beginning of FY 2011, the Division of Alcohol and Drug Abuse (ADA) terminated its contract with Oxford House, Inc. as the result of dwindling resources at ADA and a deficiency in the revolving loan balance that conflicts with the statutory requirement of at least a $100,000 balance. In the future, ADA will opt out of maintaining group homes through a revolving loan fund. The remaining balance of the revolving loan was re-allocated to fund substance abuse services.

List of group homes:

Central Region			
Bicknell **104 Bicknell** **Columbia, MO 65203** **M 573-442-7084**	**Calico** **2504 Calico St.** **Columbia, MO 65202** **M 573-474-0035**	**Cougar** **1810 Garth** **Columbia, MO 65202** **M 442-2330**	**Countryside** **2504 Quail Dr.** **Columbia, MO 65203** **M 573-219-9716**
Hubbell **1700 Countryside Lane** **Columbia, MO 65202** **W 573-219-9597**	**Leslie** **19 E. Leslie** **Columbia, MO 65202** **M 573-256-5221**	**Leslie** **19 E. Leslie** **Columbia, MO 65202** **M 573-256-5221**	**Proctor** **314 Proctor Dr.** **Columbia, MO 65202** **M 573-874-9610**
Sondra **921 Sondra** **Columbia, MO 65202** **M 573-875-5721**	**W/ Broadway** **2402 W. Broadway** **Columbia, MO 65203** **W 573-514-4310**	**Willowbrook** **2501 Willowbrook** **Columbia, MO 65202** **M 573-474-0741**	

Eastern Region			
Allendale **3127 Meramec** **St. Louis, MO 63118** **M 314-353-5823**	**Chippewa** **6408 Chippewa** **St, Louis, MO 63109** **V 314-353-2771**	**Clayton** **6957 Clayton Rd.** **St. Louis, MO 63117** **M 314-863-7669**	**Fairview** **2171 Hwy. 61** **Festus, MO 63028** **M 636-937-2514**
Gravois **3943 Gravois** **St. Louis, MO 63116** **M 314-772-1303**	**Humphrey** **3542 Humphrey** **St. Louis, MO 63118** **M 314-762-9976** **314-762-9794**	**Jarman** **4506 S. Grand** **St. Louis, MO 63118** **W 314-351-1567**	**Kensington** **5058 Kensington** **St. Louis, MO 63108** **M 314-367-7962**
Lincoln-Midwest **1663 Lincoln Dr.** **St. Charles, MO 63303** **M 636-493-1385**	**Lynncove** **1751 Lynncove Lane** **St. Charles, MO 63303** **M 636-724-4562**	**Lusher** **11876 Lusher Rd.** **St. Louis, MO 63138** **M 314-741-7536**	**McCausland** **2017 McCausland** **St. Louis, MO 63143** **M 314-644-0971**
McDonough **527 McDonough** **St. Charles, MO 63301** **M 636-947-6730**	**Michigan** **7127 Michigan** **St. Louis, MO 63111** **M 314-351-2712**	**Monitor** **3633 Meramec** **St. Louis, MO 63116** **W 314-752-1213**	**Montana** **3655 Montana** **St. Louis, MO 63116** **M 314-351-2064**
Oak Lake **4004 Ashby Rd.** **St. Louis, MO 63047** **W 314-432-5514**	**Osage** **2715 Osage** **St. Louis, MO 63118** **W 314-7726771**	**Portis** **4430 Arsenal** **St. Louis, MO 63116** **M 314-776-5825** **314-776-7076**	**Raymond** **1376 Trampe** **St. Louis, MO 63138** **V 314-653-653-6544**
S. Pacific **540 S. Pacific** **Cape Girardeau, MO 63703** **W 573-651-4646**	**St. Charles** **1047 Washington** **St. Charles, MO 63303** **M 636-493-1751**	**Shenandoah** **720 Shenandoah** **St. Louis, MO 63104** **M 314-776-4883**	**South Jefferson** **827 Jefferson** **Cape Girardeau, MO 63703** **M 573-651-6066**
Winfield **60 Franke Dr.** **Winfield, MO 63389** **M 636-566-6258**			
Western Region			
Blue Hills **1832 E. 49th St.** **Kansas City, MO 64130** **M 816-923-7696**	**Chouteau** **4401 N Walrond Ave.** **Kansas City, MO 64117** **M 816-632-9851**	**Harrison** **26 E. Concord** **Kansas City, MO 64112** **M 816-216-1883**	**Hillcrest** **9615 Freemont** **Kansas City, MO 64134** **M 816-761-3948**
Holmes **2641 Holmes** **Kansas City, MO 64108** **M 816-842-1634**	**KC Crossroads** **1832 Washington** **Kansas City, MO 64108** **W 816-569-1345**	**Karnes** **3734 Walnut** **Kansas City, MO 64111** **W 816-232-4773**	**Marlboro** **1410 E 77th Terrace** **Kansas City, MO 64131** **M 816-333-2267**
Raytown **10905 E. 62nd Terrace** **Raytown, MO 64133** **M 816-358-6495**	**Rockhill** **5632 Charlotte** **Kansas City, MO 64108** **W 816-569-2325**		

Northwestern Region			
Felix **1419 Felix** **St. Joseph, MO 64501** **M 417-232-4773**	**Museum** **1210 Felix** **St. Joseph, MO 64501** **M 816-689-3825**	**St. Joseph** **507 S. 10th Street** **St. Joseph, MO 65401** **M 816-232-8988**	**Truman** **400 S. Hocker** **Independence, MO 64050** **M 816-833-0222**
Southwestern Region			
Catalina **1674 S. Catalina** **Springfield, MO 65804** **M 417-887-7783**	**Kerr** **953 W. Kerr** **Springfield, MO 65803** **M 417-368-9199**	**Moffett** **529 Moffet** **Joplin, MO 64801** **M 417-623-4347**	**United** **1558 W. Cherokee** **Springfield, MO 65807** **M 417-887-7783**

Goal #8: Tobacco Products

An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. §300x-26, 45 C.F.R. §96.130 and 45 C.F.R. §96.122(d)).

• Is the State's FY 2012 Annual Synar Report included with the FY 2012 uniform application? (Yes/No)

• If No, please indicate when the State plans to submit the report: (mm/dd/2011)

Note: The statutory due date is December 31, 2011.

Missouri plans to submit the FFY 2012 Annual Synar Report with the FFY 2012 SAPT Block Grant application.

Goal #9: Pregnant Women Preferences

An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. §300x-27 and 45 C.F.R. §96.131).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Priority admissions; Referral to Interim services; Prenatal care; Provider contracts; Routine reporting; Waiting lists; Screening/assessment; Residential treatment; Counseling; Training/TA Educational materials; HIV/AIDS/TB Testing*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

The Missouri Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA) provides specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for women and children. ADA certification standards and provider contracts require that pregnant and postpartum women be given priority admission.

This priority status was reinforced with revised contract language at the outset of FY 2010. This language is as follows:

> *1. In accordance with the requirements of the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959), Missouri state statute, and Department priorities, the contractor shall give preference for admission to certain identified populations.*
>
> *2. The Department has identified two groups of priority populations for substance abuse treatment:*
>
> > *a. Priority I populations: Priority I populations require immediate admission to detoxification or residential support unless clinically contraindicated. Priority I populations include:*
> > *· Women who are pregnant…*
>
> *3. For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.*
>
> *4. In order to provide immediate admission for priority populations, the contractor understands and agrees that clinically stable consumers may require transfer to a less intensive level of care.*
>
> *5. The contractor shall refer pregnant women to a Women and Children's CSTAR program unless the contractor's treatment team determines that the individual's needs are best met in the contractor's treatment program, and there is clear justification in the clinical record for such determination.*

Monitoring procedures were in place to assist pregnant women in accessing treatment as quickly as possible. Agency admission practices were monitored at the regional level through the District Administrators and Area Treatment Coordinators. The information system designed and maintained by DMH includes a waiting list function in addition to the regular program admission function. ADA encouraged each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care became available. Agencies within close proximity of each other developed informal telephone communications to refer consumers to other programs when they were unable to meet the needs of those consumers seeking treatment. In addition, ADA assisted agencies in locating treatment services throughout the state. ADA had a toll-free number advertised for consumers to call for referrals. Central office or regional staff received the calls and made referrals to treatment programs in the consumer's area. Compliance was monitored by certification surveys and annual Safety and Basic Assurance Reviews

utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

In addition, continued monitoring of pregnant consumer admissions through the *Substance Abuse Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care* provided the opportunity for ADA staff to work in direct collaboration with the Missouri HealthNet Division (MHD) for the purpose of communication and care coordination. The Clinical Utilization Review Unit provided information and education to the CSTAR providers and managed care health plan case managers on the purpose and procedures for implementation of the protocol; in addition to completion of periodic case reviews to ensure pregnant women and their children were receiving access to the resources and supports to meet their individual needs. Clinical Utilization Review staff participated in conference calls with ADA treatment providers, MHD, and the managed care health plans to identify problematic areas in the communication and collaboration process in an effort to improve care coordination efforts. The Clinical Utilization Review unit provided quarterly and year-end reports to MHD on the numbers of pregnant consumers served in ADA treatment programs, as well as identified areas for continued enhancement and improvement of the protocol process.

Agencies make known the prioritization of pregnant women for treatment services in a variety of ways. Examples of platforms for notification include, but are not limited to, the following:

- Websites;
- Brochures;
- Collaborative meetings with community services organizations;
- Community presentations.

Additionally, the Division of ADA staff regularly include descriptions of priority populations when making community presentations, when training agency staff, when communicating with referral sources, and when representing the Division in community services meetings. Most recently, the Division of ADA has posted a notice of SAPT Block Grant priority populations on its public website under both “Information for Consumer & Families” and “Information for Providers”: http://dmh.mo.gov/docs/ada/NoticeofFederalPriorityPopulationsforSubstanceAbuseTreatment.pdf.

Capacity Management and Waiting List Systems (formerly Attachment G)

See 45 C.F.R. §96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2010) to the fiscal year for which the State is applying for funds:

In **up to five pages**, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. §96.126(c) and 45 C.F.R. §96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of **procedures** may include, but not be limited to:
<

• development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;

• the role of the Single State Agency (SSA) for substance abuse prevention and treatment;

• the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and

• the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of **activities** may include, but not be limited to:

• how interim services are made available to individuals awaiting admission to treatment ;

• the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and

• technical assistance.

FY 2010 Capacity Management and Waiting List Systems

The Single State Agency for the State of Missouri addresses the requirements for developing capacity management and waiting list systems for intravenous drug users and pregnant women through several methods:

1. Certification Standards for Alcohol and Drug Abuse Programs

Capacity management processes for the Division of Alcohol and Drug Abuse (ADA) are addressed in certification standards which guide providers of ADA treatment services. These certification standards are codified as state regulations in the Code of State Regulations (CSR) and filed with the Missouri Secretary of State. Relevant standards include:

9 CSR 10-7.020 (Rights, Responsibilities, and Grievances), addresses access per the following:

(3) Rights Which Cannot Be Limited.

A) The following rights apply to all settings:
1. To receive prompt evaluation, care and treatment;

(6) Access to Services. An individual shall not be denied admission or services solely on the grounds of prior treatment, withdrawal from treatment against advice, or continuation or return of symptoms after prior treatment.

9 CSR 10-7.030 (1) (Service Delivery Process and Documentation) requires each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed.

(A) At the individual's first contact with the organization (whether by telephone or face-to-face contact) any emergency or urgent service needs shall be identified and addressed.

1. Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. A person who presents at the program site with emergency service needs shall be seen by a qualified staff member within fifteen (15) minutes of presentation. If emergency service needs are reported by telephone, the program shall initiate face-to-face contact within one (1) hour of telephone contact or shall immediately notify local emergency personnel capable of promptly responding to the report.

2. Urgent service needs are indicated when a person presents a significant impairment in the ability to care for self but does not pose a likelihood of immediate harm to self or others. A person with urgent service needs shall be seen within forty-eight (48) hours, or the program shall provide information about treatment alternatives or community supports where available.

3. Routine service needs are indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. A person with routine service needs should be seen as soon as possible to the extent that resources are available.

(B) The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.

(C) The screening—

1. Shall be conducted by trained staff;

2. Shall be responsive to the individual's request and needs; and

3. Shall include notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community.

9 CSR 10-7.030 (3) (Service Delivery Process and Documentation) offers guidance on what clinical bases decisions be made regarding appropriate level of care assignment and ongoing service delivery.

(A) Services shall be provided in accordance with applicable eligibility and utilization criteria. Criteria specified in program rules shall be incorporated into the treatment process, applied to each individual, and used to guide the intensity, duration, and type of services provided. Decisions regarding the level of care and the treatment setting shall be based on—

1. Personal safety and protection from harm;

2. Severity of the psychiatric or substance abuse problem;

3. Emotional and behavioral functioning and need for structure;

4. Social, family and community functioning;

5. Readiness and social supports for recovery;

6. Ability to avoid high risk behaviors; and

7. Ability to cooperate with and benefit from the services offered.

9 CSR 30-3.190 (1) (Specialized Program for Women and Children) requires that in programs that provide treatment solely to women and children, priority is given to women who are pregnant or postpartum.

9 CSR 10-7.010 (6) (Treatment Principles and Outcomes) requires *(A) Services and supports shall be provided in the most appropriate setting available, consistent with the individual's safety, protection from harm, and other designated utilization criteria and (7) Essential Treatment Principle—Array of Services…*

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.

2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.

3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program…

9 CSR 30-3.100 (14) (Services Delivery Process and Documentation) requires that the ADA conduct clinical review to "*promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definition."*

9 CSR 30-3.132 (5) (Opioid Treatment Program) requires *"the program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive."*

Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. In addition, communities are implementing recovery oriented systems of care of which participants include state contracted providers that assist in communications and coordination of care. Also, ADA assists agencies in locating referral resources throughout the state. ADA staff are facilitating provider meetings to exchange information and foster increased communications among and between provider organizations.

The certification standards are part of the ongoing operations of ADA. In addition, the statewide network of treatment providers offer an easy vehicle for communication across provider agencies on topics related to treatment capacity. No direct costs can be attributed to complying with the capacity management and waiting list requirements of the block grant.

2. Information System

DMH implemented a new information system, Customer Information Management, Outcomes, and Reporting (CIMOR), at the beginning of October 2006, which offers all organizations the option of using a tool in this system to manage waiting lists. This is available for access to all the organizations that have contracts with ADA. Providers are encouraged by ADA to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care are available.

During FY11, ADA convened a capacity management workgroup that included staff from the treatment, fiscal, and research units and information technology staff to develop recommendations for capacity management and wait list. The group met regularly over the course of eight months. In May 2011, a proposal to add a new

capacity management screen to the CIMOR information system was finalized. This new screen will capture capacity and census data by type of program, modality, gender status, and level of care. The finalized proposal was submitted to the CIMOR steering committee for their review and approval. That approval was granted in late spring 2011. The capacity management project is now on the list for CIMOR development.

The CIMOR system is a component of the DMH's consumer information infrastructure. Costs for complying with block grant capacity management and waiting list requirements are part of the ongoing costs of this infrastructure and cannot be estimated.

3. Toll-free Telephone Number and ADA Website

ADA has a toll-free number advertised for consumers to call to obtain referral information. Either central office or regional staff receive the calls and offer referrals to treatment programs in the consumer's area. In addition, ADA maintains a website, which provides the public with information regarding substance use and links to treatment facilities.

4. Contractual Requirements

A long standing policy of ADA has been to prioritize the admission and treatment of pregnant women and intravenous drug users (IVDUs). When members of these priority populations present for services, they are promptly screened, assessed, and engaged in the level and intensity of care that is commensurate with their clinical needs.

This priority status was reinforced with revised contract language at the outset of FY 2010. This language is as follows:

1. *In accordance with the requirements of the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959), Missouri state statute, and Department priorities, the contractor shall give preference for admission to certain identified populations.*
2. *The Department has identified two groups of priority populations for substance abuse treatment:*
    a. *<u>Priority I populations</u>: Priority I populations require immediate admission to detoxification or residential support unless clinically contraindicated. Priority I populations include:*
        - *Women who are pregnant.*
        - *Intravenous (IV) drug users who have injected drugs in the prior 30 days. May be referred for immediate admission to an opioid treatment program, if safe and clinically appropriate…*

3. *For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.*
4. *In order to provide immediate admission for priority populations, the contractor understands and agrees that clinically stable consumers may require transfer to a less intensive level of care.*
5. *The contractor shall refer pregnant women to a Women and Children's CSTAR program unless the contractor's treatment team determines that the individual's needs are best met in the contractor's treatment program, and there is clear justification in the clinical record for such determination.*

The prior policy had worked reasonably well in light of limited resources, but the contract language formalizes the Division's expectations. Compliance with this policy will be monitored by certification surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

ADA does not identify costs separately for capacity management and waiting list systems; these costs are included in our administrative costs.

In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. A technical assistance site visit occurred in August 2010. That site visit included a review of current policies, procedures, information system functionality, Block Grant statutory requirements, and strategies for collecting capacity management and wait list data. The visit included a conference call with service providers to gain perspective from the provider level given their policies, procedures, and day-to-day operations. ADA convened a capacity management workgroup that included staff from the treatment, fiscal, and research units and information technology staff to develop recommendations for capacity management and wait list. The group met regularly over the course of eight months. In May 2011, a proposal to add a new capacity management screen to the CIMOR information system was finalized. This new screen will capture capacity and census data by type of program, modality, gender status, and level of care. The finalized proposal was submitted to the CIMOR steering committee for their review and approval. That approval was granted in July 2011. The capacity management project is now on the list for CIMOR development. In the interim, ADA is developing a process outside of CIMOR to collect wait list and capacity management information from providers on a weekly basis. The tentative date for providing the instructions and tracking form to providers is May 1, 2012. Since providers will need some time to adjust current processes, the tentative implementation date is July 1, 2012. Implementation of this new data collection process is expected to occur with the roll out of new contract language regarding priority populations and the provision of interim services.

Goal #10: Process for Referring

An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. §300x-28(a) and 45 C.F.R. §96.132(a)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Training/TA; Implementation of ASAM criteria; Use of Standardized assessments; Patient placement using levels of care; Purchased/contracted services; Monitoring visits/inspections; Work groups/task forces; Information systems; Reporting mechanisms; Implementation protocols; Provider certifications.*

FY2009 (Annual Report/Compliance):

FY 2009 (Compliance)

The Addiction Severity Index (ASI) was the primary assessment tool used to determine level of care for consumers age eighteen years and older. The ASI is a structured clinical interview which is typically conducted in less than fifty minutes at the time of the consumer's admission. This assessment tool encompasses seven areas of life functioning: medical status; employment status; drug and alcohol use; family history; family and social relationships; legal status; and psychiatric status. Since October 2006, the assessment has been available on the Customer Information Management, Outcomes and Reporting (CIMOR) system.

Beginning FY 2007, adolescent Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs were required to utilize the Global Appraisal of Individual Needs (GAIN). The GAIN is an evidence-based full bio-psychosocial assessment that is valid in many different treatment settings. It integrates research and clinical assessment to complete diagnosis, placement, individualized treatment planning, program evaluation, and reporting requirements. The GAIN has eight core sections: Background, Substance Use, Physical Health, Risk Behaviors and Disease Prevention, Mental and Emotional Health, Environment and Living Situation, Legal and Vocational. The GAIN provides a comprehensive, standardized tool with which to ensure appropriate consumer placement and service referrals.

ADA staff reviewed assessment and utilization data on an agency-by-agency basis to identify major trends, problem areas, and successful outcomes. Providers utilized the computerized assessment tool in combination with clinical judgment to assure consumers were provided the most appropriate level of care. The tools used in the assessment process provided the ability to perform utilization review and outcome measurement.

Assessment results should assist clinicians in determining the most appropriate, initial level of care. In addition, certification standards outline eligibility requirements for admission into each level of the continuum of care:

9 CSR 30-3.120 Detoxification…

(3) Eligibility Criteria: In order to be eligible for detoxification services, a person must present symptoms of intoxication, impairment or withdrawal and also must require supervision and monitoring of their physical and mental status to ensure safety. A person qualifies for detoxification services on a residential basis if one or more of the following additional criteria are met:

(A) Demonstrates a current inability to minimally care for one self;

(B) Lacks a supportive, safe place to reside and demonstrates a likelihood of continued use of alcohol or other drugs;

(C) Requires ongoing observation and monitoring of vital signs due to a prior history of physical complications associated with withdrawal or the severity of current symptoms of intoxication, impairment or withdrawal; or

(D) Presents a likelihood of harm to self or others as a result of intoxication, impairment or withdrawal.

9 CSR 30-3.140 Residential Treatment…

(2) Eligibility Criteria: In order to fully participate in and benefit from the intensive set of services offered in residential treatment, a person must meet the following admission and eligibility criteria:

(A) Does not demonstrate symptoms of intoxication, impairment or withdrawal that would hinder or prohibit full participation in treatment services. A screening instrument, that includes vital signs, must be used with all prospective clients to identify symptoms of intoxication, impairment, or withdrawal and, when indicated, detoxification services must be provided or arranged;

(B) Needs an alternative, supervised living environment to ensure safety and protection from harm;

(C) Meets the general treatment eligibility requirement of a current diagnosis of substance abuse or dependence and, in addition, demonstrates one or more of the following:

1.Recent patterns of extensive or severe substance abuse;

2.Inability to establish a period of sobriety without continuous supervision and structure;

3.Presence of significant resistance or denial of an identified substance abuse problem; or

4.Limited recovery skills and/or support system; and

(D) A client may qualify for transfer from outpatient to residential treatment if the person:

1.Has been unable to establish a period of sobriety despite active participation in the most intensive set of services available on an outpatient basis; or

2. Presents imminent risk of serious consequences associated with substance abuse.

9 CSR 30-3.130 Outpatient Treatment…

(4) Community-Based Primary Treatment: This level of care is the most structured, intensive, and short-term service delivery option. Structured services shall be offered at least five (5) days per week and should approximate the service intensity of residential treatment.

(A) Eligibility for primary treatment shall be based on:

1.Evidence that the person cannot achieve abstinence without close monitoring and structured support; and

2.Need for frequent, almost daily services and supervision.

(5) Intensive Outpatient Rehabilitation: This level of care offers an intermediate intensity and duration of treatment. Services should be offered on multiple occasions during each week.

(A) Eligibility for intensive outpatient rehabilitation shall be based on:

1.Ability to limit substance use and remain abstinent without close monitoring and structured support;
2.Absence of crisis that cannot be resolved by community support services;
3.Evidence of willingness to participate in the program, keep appointments, participate in self-help, etc.; and
4.Willingness, as clinically appropriate, to involve significant others in the treatment process, such as family, employer, probation officer, etc.

(6) Supported Recovery: This level of care offers treatment on a regularly scheduled basis, while allowing for a temporary increase in services to address a crisis, relapse, or imminent risk of relapse. Services should be offered on approximately a weekly basis, unless other scheduling is clinically indicated.

(A) Eligibility for supported recovery shall be based on:
1.Lack of need for structured or intensive treatment;
2.Presence of adequate resources to support oneself in the community;
3.Absence of crisis that cannot be resolved by community support services;
4.Willingness to participate in the program, keep appointments, participate in self-help, etc.
5.Evidence of a desire to maintain a drug-free lifestyle;
6.Involvement in the community, such as family, church, employer, etc.; and
7.Presence of recovery supports in the family and/or community.

9 CSR 30-3.132 Opioid Treatment Program…

(5) Admission Criteria: The program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive. Persons who are not residents of the state of Missouri shall comprise no more than twenty percent (20%) of the clients of the program.

(A) In order to qualify for medically supervised withdrawal, the applicant must demonstrate physiologic dependence to narcotics. Documentation must indicate clinical signs of dependence, such as needle marks, constricted or dilated pupils, etc.

(B) In order to qualify for initial admission to ongoing opioid treatment, the applicant must demonstrate physiologic dependence and continuous or episodic addiction for the one (1)-year period immediately prior to application for admission. Documentation must indicate clinical signs of dependence, past use patterns and treatment history, etc. The following exceptions may be made to the minimum admission requirements for opioid treatment:

1.The program may place a pregnant applicant on a methadone treatment regimen, regardless of age, if the applicant has had a documented dependency on heroin or other morphine-like drugs in the past and may be in direct jeopardy of returning to such dependency, with its attendant dangers during pregnancy. The applicant need not show evidence of current physiologic dependence if a program physician certifies the pregnancy and, in his/her reasonable clinical judgment, justifies opioid treatment;

2.For an applicant who is under the age of eighteen (18), the program shall document two (2) unsuccessful attempts at drug-free treatment prior to admission to ongoing opioid treatment. The program shall not admit any person under the age of sixteen (16) to a program without the prior approval of ADA; and

3.An applicant who has been residing in a correctional institution for one (1) month or longer may enroll in a program within fourteen (14) days before release or discharge or within six (6) months after release from such an institution without evidence of current physiologic dependence on narcotics provided that prior to institutionalization the client would have met the one (1)-year admission criteria.

(C) In order to qualify for readmission to opioid treatment, the applicant must demonstrate current physiologic dependence.

1.The program may waive this requirement if it documents prior opioid treatment of six (6) months or more and discharge within the past two (2) years.

2.At the discretion of its medical director, the program may require an applicant who has received administrative detoxification due to an infraction of program rules to wait a minimum of thirty (30) days prior to applying for readmission.

(D)The medical director may refuse the admission of an applicant and/or opioid treatment to a particular client if, in the reasonable clinical judgment of the medical director, the person would not benefit from such treatment. Prior to such a decision, appropriate staff should be consulted and the reason(s) for the decision must be documented by the medical director.

ADA's Clinical Utilization Review Unit monitored agencies' level assignments to the initial level of care given information provided via the CIMOR system and clinical information supplied by providers during the utilization review process. Any concerns related to the referral of individuals to the most appropriate treatment modality could then be followed up on with the providers and appropriate ADA staff. The certification standards outlining the clinical utilization review process are as follows:

(14) Clinical Utilization Review: Services are subject to clinical utilization review when funded by the department or provided through a service network authorized by the department. Clinical utilization review shall promote the delivery of services that are

necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definitions.

(A)The department shall have authority in all matters subject to clinical utilization review including client eligibility and service definition, authorization, and limitations.

(B)Any service matrix or package that is developed by the department or its authorized representative shall include input from service providers.

(C)Clinical utilization review shall include, but is not limited to, the following situations regarding an individual client:

1.Length of stay beyond any specified maximum time period;

2.Service authorization beyond any specified maximum amount or cost;

3.Admission of adolescents into adult programs; and

4.Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA.

(D)Clinical utilization review may be required of any client's situation and needs prior to initial or continued service authorization.

(E)The need for clinical utilization review may be identified and initiated by a provider, an individual client, or by the department.

(F)Clinical utilization review may include, but is not limited to, the following situations regarding a program:

1.Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA regarding the utilization of particular services and total service costs; and

2.Compliance issues related to certification standards or contract requirements that can reasonably be monitored through clinical review.

(15) Credentialed Staff: Clinical utilization review shall be conducted by credentialed staff with relevant professional experience.

Another important avenue to providing the most appropriate, individualized treatment modality to those seeking substance abuse treatment is access to specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs. The Division of ADA maintained contracts with CSTAR programs throughout the state to provide specialized services to populations including women and children, adolescents, and opioid-dependent consumers.

The CSTAR specialized programs for women and children provide treatment, rehabilitation, and other supports solely to women and their children. These programs focus on therapeutic issues relevant to women including parenting, relationship issues, self-esteem/self-identification, domestic violence, sexuality, health, and spirituality. The women's CSTAR programs also provide or arrange for daycare and therapeutic services for children who accompany their mothers in treatment. The CSTAR specialized programs for adolescents provide treatment, rehabilitation, and other services solely to consumers between the ages of twelve and seventeen inclusive, and their families. These programs focus on therapeutic issues relevant to adolescents

including recovery issues such as peer relationships; use of leisure time; abuse and neglect; skill development, such as decision-making and study skills; and information and education regarding adolescent developmental issues and sexuality. The adolescent CSTAR programs also have an emphasis on family support and involvement, as appropriate. The opioid CSTAR programs are designed to utilize physician-prescribed methadone to assist opiate-addicted consumers withdraw from these drugs under medical supervision. Addiction treatment services are provided during and after the withdrawal protocol to help the individuals develop life skills and a recovery-focused lifestyle.

Goal #11: Continuing Education

An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. §300x-28(b) and 45 C.F.R. §96.132(b)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Counselor certification; Co-occurring training; ATTCs training; Motivational interviewing training; HIV/AIDS/TB training; Ethics training; Confidentiality and privacy training; Special populations training; Case management training; Train-the-trainer model; Domestic violence training; Faith-based training; Suicide prevention training; Crisis intervention training.*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

Due to severe economic conditions, the Missouri Department of Mental Health's (DMH) annual Spring Training Institute was cancelled for 2009.

The Division of Alcohol and Drug Abuse (ADA) Access to Recovery (ATR) staff continued to provide training to the clinical treatment and recovery support providers throughout the state. Technical assistance trainings included ensuring proper documentation and educating on invoicing techniques, as well as providing information on appropriate business practices. ADA/ATR staff continued to partner with Committed Caring Faith Communities (CCFC), an independent statewide 501(c)(3) interfaith corporation, in presenting the Addictions Academy which is designed to educate recovery support providers on best practices in the field of addiction counseling and the faith communities' role in helping consumers recover. Training on the Government Performance and Results Act (GPRA) and the ATR voucher management system were and are available to both clinical and recovery support providers upon request.

Regional Collaborative Model trainings provided subsequent cross-training opportunities for the Division of Alcohol and Drug Abuse (ADA) and the Department of Health and Senior Services (DHSS) contracted providers. Participating DHSS and ADA treatment staff were provided with updated regional epidemiological data and responsive risk reduction methods to address consumer health risk factors associated with HIV/AIDS, STDs, TB, and Hepatitis. Regional collaboration plans were revised and updated to reflect the current progression of this regional service delivery model. Through regional trainings, additional action steps were identified to increase collaboration, resource development, and regional responsiveness.

ADA worked collaboratively in partnership with DHSS to provide the HIV pre- and post-test counseling training to DMH contracted provider staff. The DHSS has made the commitment to ADA to make their HIV trainings open to all ADA provider staff at no cost to the providers. ADA provider staff has been encouraged to pursue this required training at the regional level with their DHSS and local Department of Health staff.

ADA provided training, education, and technical assistance through the Missouri Statewide Training and Resource Network (STRC). Training and technical assistance were provided to Regional Support Center staff and community leaders to promote community development, accountability, and targeted prevention initiatives based on the Center for Substance Abuse Prevention's (CSAP) best practices program recommendations.

The Southwest Center for the Application of Prevention Technology (SWCAPT) continued to provide technical assistance to ADA to support the implementation of Missouri's Strategic Prevention Framework State Incentive Grant (SPFSIG) as prevention providers and community coalitions respond to the requirements for data driven targeted prevention intervention strategies.

Beginning in 2008, ADA required contracted direct service prevention staff to obtain the first level prevention credential with the Missouri Substance Abuse Professional Credentialing Board (MSAPCB). ADA worked with the MSAPCB to develop criteria for the three levels of Prevention Specialists credentials for Missouri: Missouri Substance Abuse Prevention Associate (MSAPA), Certified Reciprocal Prevention Specialist (CRPS), and Missouri Advanced Certified Substance Abuse Prevention Professional (MACSAPP).

ADA regional prevention staff continued to provide technical assistance to providers of the School-based Prevention Intervention and Resources Initiative (SPIRIT) to encourage their utilization of best practices and science-based intervention services.

Goal #12: Coordinate Services

An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. §300x-28(c) and 45 C.F.R. §96.132(c)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Convened work groups/task force/councils; Conduct training/TA; Partnering with association(s)/other agencies; Coordination of prevention and treatment activities; Convening routine meetings; Development of polices for coordination; Convening town hall meetings to raise public awareness; Implementation of evidence-based services.*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

The advisory council network continued to be an important link between the public and the Division of Alcohol and Drug Abuse (ADA). The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), is established by state statute and is an advisory body to the Director of ADA. The SAC is comprised of 25 members appointed by the ADA Director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. At least one-half of the members must be consumers (non-providers) of services and no more than one-fourth can be ADA treatment or prevention contract providers. The SAC collaborates with ADA in developing a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse; and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol and other drug abuse. The SAC reviews current trends and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public treatment programs and other specialized services. The SAC recommends specific methods, means, and procedures that should be adopted to improve and upgrade the service delivery system and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding.

The following certification standards address the coordination of treatment services. Certification standard 9 CSR 10-7.010, Treatment Principles and Outcomes, states the following:

(7) (A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. *The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.*
2. *Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.*
3. *To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.*
4. *Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.*
5. *Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals.*

Workgroups established between the Office of State Courts Administrator (OSCA) and

ADA developed policies and procedures for consumers involved in Missouri Drug Courts. Similarly, the Department of Corrections and ADA work together to develop reentry programs to prevent relapse and recidivism. Community support workers are required to maintain an active directory of community and state resources, which are available to consumers who are involved in CSTAR substance abuse treatment programs. Further assurances of collaboration between ADA providers and community/state resources are monitored through certification visits and clinical reviews through CIMOR.

Adolescent Comprehensive Substance Treatment and Rehabilitation (CSTAR) program certification standard 9 CSR 30-3.192 (3) (F) requires the following:

Cooperation with other youth-serving agencies shall be demonstrated in order to ensure that the needs of youth in treatment are met and that services are coordinated. Coordination of service needs is critical with youth due to their involvement with other community agencies and reliance on the family, as well as the fact that substance abuse affects multiple life areas.

Coordination of education for adolescent consumers during treatment is required by standards. All consumers in CSTAR programs are offered a community support worker whose responsibilities include “activities with or on behalf of a particular consumer in accordance with an individual rehabilitation plan to maximize the consumer’s adjustment and functioning within the community while achieving sobriety and sustaining recovery, maximizing the involvement of natural support systems, and promoting consumer independence and responsibility.” The community support worker arranges, refers, and monitors services external to the CSTAR program.

Each CSTAR Women and Children's program is required to provide a child care and development program for the children of women who are concurrently receiving treatment. Each center, as required in certification standards, must design appropriate services that address the following goals: build self esteem; learn to identify and express feelings; build positive family relationships; develop decision-making skills; understand chemical dependency as a family illness; and learn and practice non-violent ways to resolve conflict. Each child receives an individual assessment to determine his/her needs, and appropriate intervention or referral is arranged. Children can receive individual and family therapy and group codependency counseling from qualified personnel. The mothers receive extensive weekly training on parenting skills and supervised parent/child bonding time to practice the new skills. The women and their children receive residential support or supportive housing to assure a safe, drug-free environment.

All women and children who enter treatment are provided health screenings by registered nurses to identify health deficits or needs for medical intervention. Close association with local health clinics provides prenatal care, immunizations and other preventive techniques to increase the well-being of mothers and their children. For women receiving day treatment and outpatient services, transportation is available to

and from the facility. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. The dependent children are provided child care and treatment for physical, emotional, and behavioral conditions brought about by their mothers' addiction.

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the Department of Health and Senior Services (DHSS) to access current information, trends and training related to the prevention and treatment of tuberculosis (TB) in high-risk groups. ADA required contracted treatment providers to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. ADA continued to work with the DHSS to maintain community linkages with contracted treatment providers to encourage effective utilization of state and community resources. Contracted treatment providers performed HIV, TB, STD, and hepatitis risk assessments for all consumers. High risk consumers were provided pre-test counseling, testing referral, and post-test counseling services. ADA designated staff continued to serve as liaisons with DHSS and ADA contracted treatment providers to respond to incidents or questions and to provide assistance with dissemination of infectious disease information.

ADA continued to work with the DHSS on the placement of Fetal Alcohol Syndrome (FAS) infant manikins. The manikins, placed in CSTAR sites and Regional Support Centers (RSCs) are an educational tool for FAS prevention. ADA continued to work collaboratively with the DHSS on the Fetal Alcohol Syndrome (FAS) prevention initiative identified as the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP). ADA continued training the five participating Women and Children's CSTAR programs as needed. The training included fundamentals of Motivational Interviewing and instructions for providing the Healthy Balance Intervention Strategy to eligible women receiving treatment in the five CSTAR programs. Additional educational FAS curriculum continued to be used by the participating CSTAR sites for consumer education.

ADA continued support for the Missouri School-based Prevention Intervention and Resources Initiative (SPIRIT) in the existing five school sites in Missouri, with one site located in each of the five ADA sub-state regions. The Missouri SPIRIT program is a collaborative between ADA, the school site, the contracted agency, and the evaluator. SPIRIT continued to provide evidence-based prevention programs to students in grades K-12 using universal, selective, and indicated preventive interventions. The curriculums used in the SPIRIT initiative included Positive Action, Life Skills Training, Second Step, Too Good for Drugs, Project Towards No Drug Abuse, Peace Builders, and Reconnecting Youth. Outcome measurement included use of the Teacher Observation Checklist (K-3), the Fidelity and Quality of Program Implementation Report, a revised Healthy Kids Survey (grades 4-5), the SPIRIT Survey for (grades 6-12), and the Youth Satisfaction Survey.

ADA continued to partner with representatives of local, state, and national level agency

work groups, task forces, and councils to coordinate substance abuse prevention efforts. These groups target specific issues and age groups including: the Missouri Coordinated School Health Coalition (MCSHC), Council for Adolescent School Health (CASH), the Suicide Prevention Advisory Council; Screening, Brief Intervention, Referral, and Therapy (SBIRT) workgroup; Mental Health Transformation workgroups, and the National Organization on Fetal Alcohol Syndrome (NOFAS)-Missouri.

ADA continued to collaborate with Missouri Department of Elementary and Secondary Education (DESE) for the Internet-based administration of the 2008 Missouri Student Survey (MSS).

Under ADA direction, one statewide and forty-seven local coalitions hosted Town Hall Meetings (THMs) supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The 2008 THMs focused attention on the critical public health and safety issue and provided communities with the information and tools to answer *The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking.*

Goal #13: Assessment of Need

An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. §300x-29 and 45 C.F.R. §96.133).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Data-based planning; Statewide surveys; Youth survey(s); Archival/social indicator data; Data work groups; Risk and protective factors Household survey data utilization; Prioritization of services; Provider surveys; Online surveys/Web-based reporting systems; Site visits.*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

In the development of the State's needs assessments, a combination of data sources were studied including:

1) state and sub-state estimates from the National Survey on Drug Use and Health (NSDUH) survey,
2) state and sub-state estimates from the Missouri Student Survey (MSS),
3) state estimates from the Behavioral Risk Factor Survey (BRFS),
4) state estimates from the Youth Risk Behavior Survey (YRBS), and
5) state estimates from the Missouri College Health Behavior Survey (MCHBS).

For the treatment needs assessment, the Division of Alcohol and Drug Abuse (ADA) used the estimated number of individuals with alcohol or illicit drug dependence or abuse from the NSDUH as a proxy measure for treatment need. The treatment needs estimates were used to estimate treatment penetration rates, plan and allocate treatment services, and develop the ADA portion of the Department of Mental Health's annual budget request. The estimates were also summarized in the annual *Status Report on Missouri's Alcohol and Drug Abuse Problems* (http://www.dmh.missouri.gov/ada/rpts/status.htm). During FY 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) released national and state estimates from the combined 2006-2007 National Survey on Drug Use and Health (NSDUH). ADA developed tables to compare national and Missouri rates for several measures and indicators from the survey. These tables were included in the ADA status report.

ADA collected an array of substance abuse indicator data, mostly from other state agencies. The indicators included a variety of alcohol and drug related events including traffic crashes, fatalities, injuries, and DUI arrests; HIV/AIDS cases; hospital and emergency room admissions; impaired births; induced deaths; adult and juvenile arrests; school discipline incidents; out-of-home juvenile placements, methamphetamine lab confiscations; probation, parole, and prison admissions; and drug court enrollments. In addition, ADA also collected other indicator data including school dropouts, juvenile status offenses, domestic violence, violent and property crime indices, and unemployment. ADA annually assembles the indicators into geographic profiles for Missouri's 114 counties plus the city of St. Louis, the 5 ADA planning regions, 20 service areas, and the state. This data is published in the ADA Annual Status Report. Also included in the status report is narrative discussion of the highlights and trends of the data, the economic costs of substance abuse, and the challenges in addressing substance abuse issues.

The biennial MSS survey was scheduled for 2010 and planning for that survey occurred in FY 2009. The MSS survey represents a collaborative effort between the Department of Elementary and Secondary Education (DESE) and ADA. The survey instrument collects data on substance abuse incidence and prevalence, delinquent behavior, and risk and protective factors related to a range of health and safety issues. Reports summarizing findings of the MSS survey are published to the ADA public website: http://dmh.mo.gov/ada/rpts/survey.htm.

Missouri awarded Strategic Prevention Framework State Incentive Grant (SPF SIG) funding to 18 community-based coalitions in FY 2008, and extended funding to 2 statewide prevention coalitions -- Partners in Prevention and Missouri's Youth/Adult Alliance -- in FY 2009. Missouri's goal under this grant was to reduce risky drinking behavior, especially binge and underage alcohol use among the population 12-25 years of age. The 20 SPF SIG sub-recipient coalitions continued to develop their projects in FY 2009 by refining their assessments of resources, needs, and community readiness; implementing evidence-based programs and environmental strategies; and collecting, reviewing, and submitting data needed for program evaluations. The SPF SIG staff and the Regional Support Centers continued to provide training workshops and technical assistance to enhance the planning, program implementation, and evaluation capabilities of the SPF SIG coalitions. The Regional Support Centers also assisted 152 other community coalitions to conduct prevention needs assessments.

Goal #14: Hypodermic Needle Program

An agreement to ensure that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. §300x-31(a)(1)(F) and 45 C.F.R. §96.135(a)(6)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prohibitions written into provider contracts; Compliance site visits; Peer reviews; Training/TA.*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

The Division of Alcohol and Drug Abuse (ADA) continued the policy that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. Billing for such was not and is not possible in the Customer Information Management, Outcomes, and Reporting (CIMOR) system used by all contracted providers.

Policy adherence was ensured through various monitoring mechanisms: three-year certification surveys; Annual Safety and Basic Assurance Reviews, which included billing reviews; and, periodic site visits by the District Administrators and Area Treatment Coordinators.

Goal #15: Independent Peer Review

An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. §300x-53(a) and 45 C.F.R. §96.136).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Peer review process and/or protocols; Quality control/quality improvement activities; Review of treatment planning reviews; Review of assessment process; Review of admission process; Review of discharge process; achieving CARF/JCAHO/(etc) accreditation.*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

The Division of Alcohol and Drug Abuse (ADA) utilized independent peer review as one of several methods to encourage and assess the quality, appropriateness, and efficacy of substance abuse treatment and services provided. Seven (7) independent peer reviews were conducted in FY 2009. Contracts for treatment providers required that they make staff available to perform peer reviews of other agencies in the state.

The following is the language in contracts addressing peer review requirements:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

    - A maximum of five (5) days of staff time may be required during each contract period;

    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;

    - Travel expenses will be reimbursed per the Department regulations;

    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and,

    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

Independent Peer Review (formerly Attachment H)

(See 45 C.F.R. §96.122(f)(3)(v))

In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2010 (See 42 U.S.C. §300x-53(a)(1) and 45 C.F.R. §96.136).

Examples of **procedures** may include, but not be limited to:

• the role of the Single State Agency (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;

• the role of the State Medical Director for Substance Abuse Services in the development of such procedures;

• the role of the independent peer reviewers; and

• the role of the entity(ies) reviewed.

Examples of **activities** may include, but not be limited to:

• the number of entities reviewed during the applicable fiscal year ;

• technical assistance made available to the entity(ies) reviewed; and

• technical assistance made available to the reviewers, if applicable.

FY 2010 Independent Peer Review

The Division of Alcohol and Drug Abuse (ADA) utilizes independent peer review as one of several methods to encourage and assess the quality, appropriateness, and efficacy of substance abuse treatment services provided in the state of Missouri. ADA has been contractually requiring all treatment providers to participate in independent peer review since July 1993. Contracted providers have been cooperating with this requirement each year since that time. Seven (7) reviews were conducted in FY 2009, eight (8) were conducted in FY 2010, and seven (7) were conducted in FY 2011.

The contract between ADA and the treatment provider includes language which requires each provider to participate in the peer review process. The contract states:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

    - A maximum of five (5) days of staff time may be required during each contract period;

    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;

    - Travel expenses will be reimbursed per the Department regulations;

    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and

    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the respective ADA District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators, who work as Division of ADA regional staff and who report to the ADA District Administrators, are responsible for initiating the peer review process. A provider in the same region as the agency to be reviewed is contacted and asked to participate in this process. Peer reviewers are usually senior staff members of the contracted agency. Provider staff conducting the peer reviews are offered guidance from the ADA Area Treatment Coordinator. Expectations are relayed, optional tools for data collection are provided, and possible focus areas are suggested. Focus area suggestions may be based on prior survey

findings or areas of concern identified in other site visits, or if it is known that the peer reviewing agency has particular strengths in any given area of review.

A reporting process is in place to ensure information collected through the review process is appropriately shared. Copies of the report are distributed to the respective District Administrator, the agency being reviewed and ADA's treatment and fiscal staff. The ADA District Administrator and ADA Area Treatment Coordinator review the report with the appropriate agency staff if follow-up is necessary.

The agency being reviewed cooperates by providing access to consumer records, staff, and policy and procedure documents. The reviewer utilizes this information to establish the agency's compliance with certification standards, best practices, and efficiency in operations. Both the reviewer and the agency being reviewed have an opportunity to learn from one another, to the benefit of both programs. The information is also useful to ADA's certification specialists and other staff that provide monitoring and technical assistance to the agencies statewide. In addition to contract compliance, the role of the ADA Area Treatment Coordinator is to conduct safety and basic assurances monitoring, provide technical assistance, and/or arrange for technical assistance visits. Some of the feedback provided through the peer review process includes suggestions regarding treatment planning, documentation, cultural diversity, and agency systems improvement.

Federal confidentiality regulations are observed throughout the individual peer review process. All members of the peer review team are knowledgeable of, and agree to comply with, federal confidentiality regulations in carrying out their assigned duties.

In summary, the role of ADA in Peer Reviews is as follows:

1. Providers are contractually bound to participate in Peer Reviews by ADA contracts;
2. The ADA Area Treatment Coordinators initiate the Peer Review;
3. The ADA Area Treatment Coordinators assure that the peer reviewer is a knowledgeable and experienced Substance Abuse Treatment Professional;
4. The ADA Area Treatment Coordinators assure the findings and recommendations of the Peer Review visit are reported in a timely fashion;
5. The ADA Area Treatment Coordinators review the findings and recommendations report;
6. The respective ADA District Administrator reviews the findings and recommendations of the Peer Review report;
7. The ADA District Administrator and Area Treatment Coordinator may review the report with the appropriate staff from the agency being reviewed, and provide technical assistance, if necessary.
8. The ADA District Administrator reviews significant deviations from contractual requirements or certification standards with the Executive Director of the reviewed agency;
9. The ADA District Administrator may review recurring problems with the ADA Division Director and other ADA administrative personnel;

10. The ADA District Administrator and Area Treatment Coordinator share positive findings of innovative practices in technical assistance visits to all providers to help disseminate improvements in clinical practice;
11. Copies of Peer Review findings and recommendations are filed in the agency's certification file.

Goal #16: Disclosure of Patient Records

An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. §300x-53(b), 45 C.F.R. §96.132(e), and 42 C.F.R. Part 2).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Confidentiality training/TA; Compliance visits/inspections; Licensure requirements/reviews; Corrective action plans; Peer reviews.*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

The Division of Alcohol and Drug Abuse (ADA) has complied with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and, as of April 2003, the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complied with these federal regulations in the processing, storage, and appropriate release of consumer information. ADA also required contracted service providers and business associates to comply with these regulations by incorporating the requirements into certification standards and provider contracts. All new ADA employees receive orientation and training to division policy and the federal confidentiality laws. In April 2009 all Department of Mental Health staff were reminded, by official memo, of the parameters and requirements related to the Notice of Privacy Practices for consumers of DMH-delivered services. Training and technical assistance have been provided to contracted program staff to ensure compliance with the federal regulations. ADA monitored the compliance of providers with the above confidentiality regulations through certification surveys, Safety and Basic Assurances Reviews (SBAR) and periodic site visits by District Administrators and Area Treatment Coordinators.

Goal #17: Charitable Choice

An agreement to ensure that the State has in effect a system to comply with services provided by non-governmental organizations (See 42 U.S.C. §300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. §54.8(b) and §54.8(c)(4), Charitable Choice Provisions; Final Rule (68 FR 189, pp. 56430-56449, September 30, 2003).

Note: In addressing this narrative *please specify if this provision was not applicable because State did not fund religious providers. If* the State did fund religious providers, it may want to discuss activities or initiatives related to the provision of: *Training/TA on regulations; Regulation reviews; Referral system/process; Task force/work groups; Provider surveys; Request for proposals; Administered vouchers to ensure patient choice.*

FY2009 (Annual Report/Compliance):

FY 2009 Compliance

The Missouri Code of State Regulations requires that creed not be used as criteria upon which to deny an individual admission to services. The right of consumers to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances).

The contract between the Division of Alcohol and Drug Abuse (ADA) and religious organizations that provide Block Grant treatment services requires that those agencies comply with Block Grant Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Consumers are informed of their right to Charitable Choice and are provided written acknowledgement of their alternatives. Guidelines, training, and technical assistance have been made accessible to providers.

All recovery support services were authorized through a vouchering system as the result of the consumer's free and independent choice to receive such services from a recovery support provider selected by the consumer from a menu of credentialed providers.

Charitable Choice (formerly Attachment I)

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Charitable Choice is to document how your State is complying with these provisions.

For the fiscal year prior (FY 2011) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries -Check all that Apply

- ☑ Used model notice provided in final regulations
- ☐ Used notice developed by State (Please attach a copy in Appendix A)
- ☑ State has disseminated notice to religious organizations that are providers
- ☑ State requires these religious organizations to give notice to all potential beneficiaries

Referrals to Alternative Services -Check all that Apply

- ☐ State has developed specific referral system for this requirement
- ☑ State has incorporated this requirement into existing referral system(s)
- ☑ SAMHSA's Treatment Facility Locator is used to help identify providers
- ☑ Other networks and information systems are used to help identify providers
- ☑ State maintains record of referrals made by religious organizations that are providers
- ☑ 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

The Access to Recovery grants support a voucher-based program, of which consumer choice is fundamental. Each consumer served can choose between at least two service providers, to which at least one they have no religious objection. That basic premise is repeated in all ATR policies and in trainings. This includes GPRA trainings and regional ATR meetings held every quarter. A total of 16 ATR-related trainings were held in FY 2011, all of which reinforced consumer choice as a core aspect of ATR. Additionally, a free-choice statement is printed on every ATR voucher.

Waivers (formerly Attachment J)

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d)).
- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))
- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))
- ☑ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))
- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Waivers

Waivers

If the State proposes to request a waiver at this time for one or more of the provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. §96.124(d), §96.128(d), §96.132(d), §96.134(b), and §96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to the SAMHSA Administrator following the submission of the application if not included as an attachment to the application.

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
1706 EAST ELM STREET
P.O. BOX 687
JEFFERSON CITY, MISSOURI 65102
(573) 751-4122
(573) 751-8224 FAX
www.dmh.mo.gov

September 1, 2011

Pam S. Hyde, J.D.
Administrator
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 8-1065
Rockville, Maryland 20857

Dear Administrator Hyde:

The State of Missouri is requesting a waiver for the Substance Abuse Block Grant maintenance of effort (MOE) requirement as permitted in Section 1930(c)(1) of the Public Health Service Act. As specified in the state's FY 2012 Substance Abuse Prevention and Treatment (SAPT) Block Grant application, Missouri's MOE requirement for state fiscal year (SFY) 2011 is $49,305,555. The state's actual level of expenditures for SFY 2011 is $47,762,977 – representing a shortfall of $1,542,578.

CFR 45 96.134(b) specifies that the state must demonstrate extraordinary economic conditions to include a decline in total tax revenue of at least one and one-half percent, and either unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. Missouri has experienced extraordinary economic conditions including 1) a decline in total tax revenues of 5.1 percent from SFY 2009 to SFY 2010 and 2) an increase in the state's annual unemployment rate by 1.8 percentage points from SFY 2009 to SFY 2010. In Missouri, the Office of Administration is the state agency responsible for operation of the statewide accounting payroll systems and is the custodian of the office accounting records of the state. The state's total tax revenue as reported by the Office of Administration for the periods SFY 2008 – SFY 2010 are as follows:

State Fiscal Year	State of Missouri Total Tax Revenue	Percent Change from SFY 2008	Percent Change from SFY 2009
2008 (7/1/07 – 6/30/08)	$11,518,848,956	---	---
2009 (7/1/08 – 6/30/09)	$11,079,619,036	-3.81%	---
2010 (7/1/09 – 6/30/10)	$10,511,717,815	-8.74%	-5.13%

Data Source: Missouri Office of Administration, Division of Accounting. "Schedule of Revenues, Expenditures and Transfers for the Past Five Years – All Funds." Appropriation Activity Report Fiscal Year 2010. Retrieved at: http://oa.mo.gov/acct/AAR2010/5-revexpallfunds.pdf.

The Local Area Unemployment Statistics (LAUS) program is a Federal-State cooperative effort in which monthly estimates of total employment and unemployment are prepared for various geographical areas including states. In Missouri, the LAUS program is administered by the Missouri Economic Research & Information Center in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics. Data for Missouri are produced using estimating equations based on regression techniques. These models combine current and historical data from the Current Population Survey (CPS), the Current Employment Statistics (CES) program, and the unemployment insurance (UI) system. Monthly unemployment rates from LAUS are averaged by state fiscal year. Missouri's unemployment rates for SFY 2008 – SFY 2010 are as follows:

State Fiscal Year	State Unemployment Rate	Percentage Point Change from SFY 2008	Percentage Point Change from SFY 2009
2008 (7/1/07 – 6/30/08)	5.39%	---	---
2009 (7/1/08 – 6/30/09)	7.82%	+2.43%	---
2010 (7/1/09 – 6/30/10)	9.62%	+4.23%	+1.8%

Data Source: Missouri Department of Economic Development, Missouri Economic Research and Information Center. Missouri Local Area Unemployment Statistics July 2007 – June 2010. Retrieved at: http://www.missourieconomy.org/indicators/laus/default.aspx.

We believe the data demonstrates that Missouri has experienced extraordinary economic conditions as defined by CFR 45 96.134(b). Furthermore, these conditions have impacted the single state authority's ability to comply with the SAPT Block Grant MOE requirements for SFY 2011 as will be reported in the FFY 2012 SAPT Block Grant application. The state hereby requests a waiver of the SAPT Block Grant MOE requirements. Your consideration is greatly appreciated. If you have any further questions or concerns, please let me know.

Sincerely,

Keith Schafer, Ed.D.
Director

KS:cl
cc: Christopher Craft, CSAT Public Health Advisor
Mark Stringer, DMH, Director, Division of Alcohol and Drug Abuse
Attachments: Letter of Delegation
State of MO Schedule of Revenues, Expenditures and Transfers for the Past Five Years – All Funds

GOVERNOR OF MISSOURI

JEFFERSON CITY
65102

JEREMIAH W. (JAY) NIXON
GOVERNOR

P.O. Box 720
(573) 751-3222

August 23, 2010

Barbara Orlando, Grants Management Officer
Division of Grants Management
Office of Program Services
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Orlando:

I hereby delegate authority to the Director or in his/her absence Deputy Director of the Missouri Department of Mental Health to sign funding agreements and certifications, provide assurances of compliance to the Secretary and to perform similar acts relevant to the administration of the Substance Abuse Prevention and Treatment (SAPT) Block Grant and Annual Synar Report until such time as this delegation of authority is rescinded.

Sincerely,

Jeremiah W. (Jay) Nixon
Governor

Missouri Local Area Unemployment Statistics (LAUS)

Produced by the Missouri Economic Research and Information Center in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics

Retrieved August 15, 2011

Year	Month	Labor Force	Employment	Unemployment	Rate	State Fiscal Year	Average Monthly Rate for Fiscal Year
2007	July	3,088,134	2,921,641	166,493	5.40%		
2007	August	3,045,488	2,884,976	160,512	5.30%		
2007	September	3,046,300	2,888,094	158,206	5.20%		
2007	October	3,050,886	2,897,196	153,690	5%		
2007	November	3,049,475	2,900,291	149,184	4.90%		
2007	December	3,037,458	2,879,681	157,777	5.20%		
2008	January	3,029,166	2,851,106	178,060	5.90%		
2008	February	3,021,947	2,846,292	175,655	5.80%		
2008	March	3,039,426	2,863,841	175,585	5.80%		
2008	April	3,039,511	2,895,211	144,300	4.70%		
2008	May	3,056,119	2,887,566	168,553	5.50%		
2008	June	3,096,934	2,910,449	186,485	6%	2008	5.39%
2008	July	3,090,912	2,892,814	198,098	6.40%		
2008	August	3,051,068	2,852,943	198,125	6.50%		
2008	September	3,032,189	2,842,161	190,028	6.30%		
2008	October	3,042,089	2,851,035	191,054	6.30%		
2008	November	3,034,935	2,833,709	201,226	6.60%		
2008	December	3,028,395	2,807,931	220,464	7.30%		
2009	January	3,038,087	2,771,047	267,040	8.80%		
2009	February	3,050,044	2,765,436	284,608	9.30%		
2009	March	3,055,006	2,769,405	285,601	9.30%		
2009	April	3,050,381	2,801,374	249,007	8.20%		
2009	May	3,070,269	2,793,192	277,077	9%		
2009	June	3,120,305	2,814,404	305,901	9.80%	2009	7.82%
2009	July	3,099,279	2,798,846	300,433	9.70%		
2009	August	3,054,190	2,759,288	294,902	9.70%		
2009	September	3,029,815	2,743,746	286,069	9.40%		
2009	October	3,028,247	2,746,054	282,193	9.30%		
2009	November	3,023,994	2,742,606	281,388	9.30%		
2009	December	2,993,851	2,712,325	281,526	9.40%		
2010	January	3,002,037	2,692,982	309,055	10.30%		
2010	February	3,013,165	2,697,484	315,681	10.50%		
2010	March	3,023,073	2,715,296	307,777	10.20%		
2010	April	3,024,625	2,750,402	274,223	9.10%		
2010	May	3,024,390	2,750,896	273,494	9%		
2010	June	3,059,897	2,767,796	292,101	9.50%	2010	9.62%
2010	July	3,047,430	2,751,011	296,419	9.70%		
2010	August	3,013,615	2,723,377	290,238	9.60%		
2010	September	2,999,568	2,720,618	278,950	9.30%		
2010	October	2,993,856	2,722,357	271,499	9.10%		
2010	November	2,991,455	2,710,670	280,785	9.40%		
2010	December	2,978,607	2,703,433	275,174	9.20%		
2011	January	2,991,363	2,686,996	304,367	10.20%		

Missouri Local Area Unemployment Statistics (LAUS)

Produced by the Missouri Economic Research and Information Center in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics

Retrieved August 15, 2011

Year	Month	Labor Force	Employment	Unemployment	Rate	State Fiscal Year	Average Monthly Rate for Fiscal Year
2011	February	3,009,034	2,709,887	299,147	9.90%		
2011	March	3,012,528	2,734,160	278,368	9.20%		
2011	April	3,032,032	2,777,810	254,222	8.40%		
2011	May	3,041,519	2,773,937	267,582	8.80%		
2011	June	3,072,894	2,796,146	276,748	9%	2011	9.32%

STATE OF MISSOURI
SCHEDULE OF REVENUES, EXPENDITURES AND TRANSFERS
FOR THE PAST FIVE YEARS - ALL FUNDS

	Fiscal Year 2010	Fiscal Year 2009	Fiscal Year 2008	Fiscal Year 2007	Fiscal Year 2006
REVENUES AND TRANSFERS IN					
Revenues					
Taxes	$ 10,511,717,815	$ 11,079,619,036	$ 11,518,848,956	$ 11,185,886,403	$ 10,638,366,972
Licenses, Fees and Permits	667,163,298	678,920,364	686,991,545	645,766,864	654,583,850
Sales, Services, Leases and Rentals	958,541,182	974,305,540	900,564,466	895,568,868	850,108,512
Bond Sale Proceeds	1,107,698,801	135,638,581	591,204,336	829,993,881	370,196,047
Contributions and Intergovernmental	10,850,094,418	8,798,939,700	8,039,812,788	7,332,943,218	7,277,620,521
Interest, Penalties and Unclaimed Properties	151,186,706	198,192,207	338,616,706	287,599,972	246,963,473
Refunds	370,777,202	311,552,295	280,399,521	242,515,696	428,281,832
Miscellaneous Revenues	780,438,578	799,185,777	597,318,185	522,659,048	473,441,005
Total Revenues	25,397,618,000	22,976,353,500	22,953,756,503	21,942,933,950	20,939,562,212
Total Transfers In	9,047,471,034	8,400,881,543	7,466,128,457	7,036,854,996	7,146,391,450
Total Revenues and Transfers In	$ 34,445,089,034	$ 31,377,235,043	$ 30,419,884,960	$ 28,979,788,946	$ 28,085,953,662

	Appropriation Year 2010	Appropriation Year 2009	Appropriation Year 2008	Appropriation Year 2007	Appropriation Year 2006
EXPENDITURES AND TRANSFERS OUT					
Expenditures					
Personal Service	$ 3,149,671,871	$ 3,118,954,791	$ 3,017,017,004	$ 2,937,212,067	$ 2,778,457,229
Expense and Equipment	1,545,065,039	1,656,264,240	1,540,464,722	1,650,553,875	1,567,672,210
Capital Improvements	1,398,430,086	1,299,151,593	1,157,682,440	1,313,597,998	1,204,420,755
Program Specific	17,239,375,289	16,427,546,245	15,199,153,539	14,064,085,947	13,743,238,856
Refunds (Note 6)	1,548,000,069	1,512,980,118	1,323,700,718	1,274,367,640	1,185,966,194
Court Ordered Desegregation Payments (Note 3)	9,000,000	10,000,000	11,000,000	12,000,000	13,000,000
Total Expenditures	24,889,542,354	24,024,896,987	22,249,018,423	21,251,817,527	20,492,755,244
Transfers Out	9,047,471,034	8,400,881,543	7,466,128,457	7,036,854,996	7,146,391,450
Total Expenditures and Transfers Out	33,937,013,388	32,425,778,530	29,715,146,880	28,288,672,523	27,639,146,694
Excess Revenues and Transfers In (Expenditures and Transfers Out)	$ 508,075,646	$ (1,048,543,487)	$ 704,738,080	$ 691,116,423	$ 446,806,968

The notes are an integral part of this report.

STATE OF MISSOURI
NOTES TO THE APPROPRIATION ACTIVITY REPORT
APPROPRIATION YEAR 2010

Note 1 – Basis of Accounting

The Appropriation Activity Report is prepared on a budgetary (non-GAAP) basis of accounting that records revenues when cash is received and expenditures when the liabilities are recorded.

Revenues and expenditures are reported during a twelve-month period, July 1 through June 30. During a one-month lapse period that ends July 31, corrections can be made to the revenues and expenditures processed during the period July 1 through June 30.

Note 2 – Biennial Appropriations

Biennial appropriations, which are located in House Bills 17 and 22, are appropriations to be spent over two years. The balance at June 30 of the current fiscal year is rolled over into the following appropriation year.

7/1/09 — 6/30/10
First Year of Biennials

7/1/10 — 7/31/11
Second Year of Biennials

STATE OF MISSOURI
NOTES TO THE APPROPRIATION ACTIVITY REPORT
APPROPRIATION YEAR 2010

Note 3 – Court Ordered Desegregation

The expenditures of the St. Louis Desegregation Plan are mandated by court order. Fiscal year 2010 is the last mandated payment obligation. The amounts paid for the current year and prior years are:

Appropriation Year	Projected Expenditures	Expenditures	Lapses
2010	$ 9,000,000	$ 9,000,000	$ ---
2009	10,000,000	10,000,000	---
2008	11,000,000	11,000,000	---
2007	12,000,000	12,000,000	---
2006	13,000,000	13,000,000	---
2005	15,000,000	15,000,000	---
2004	16,500,000	16,500,000	---
2003	20,000,000	20,000,000	---
2002	20,000,000	20,000,000	---
2001	50,000,000	50,000,000	---
2000	53,500,000	53,476,585	23,415
1999	191,862,972	188,799,736	3,063,236
1998	158,800,000	147,021,949	11,778,051
1997	151,700,000	138,086,852	13,613,148
1996	153,700,000	148,291,471	5,408,529
1995	155,700,000	139,258,397	16,441,603
1994	147,600,000	134,202,695	13,397,305
1993	147,100,000	136,028,438	11,071,562
1992	144,600,000	137,189,737	7,410,263
1991	135,200,000	132,695,771	2,504,229
1990	135,000,000	122,161,135	12,838,865
1989	129,000,000	116,999,047	12,000,953
1988	107,200,000	93,957,886	13,242,114
1987	84,700,000	83,473,429	1,226,571
1986	74,800,000	66,300,504	8,499,496
1985	59,200,000	57,095,304	2,104,696
1984	40,400,000	37,424,743	2,975,257
1983	21,000,000	17,187,556	3,812,444
1982	13,500,000	13,140,216	359,784
1981	10,180,490	8,530,000	1,650,490

STATE OF MISSOURI
NOTES TO THE APPROPRIATION ACTIVITY REPORT
APPROPRIATION YEAR 2010

Note 4 – General Fund

The General Fund includes General Revenue Funds and Federal Funds.

Fund Number	Fund Name
General Revenue Funds:	
0100	Budget Reserve
0101	General Revenue
0108	Uncompensated Care
0113	Health Interagency Payments
0124	Facilities Maintenance Reserve
0128	State Property Preservation
0139	Intergovernmental Transfer
0142	Federal Reimbursement Allowance
0144	Pharmacy Reimbursement Allowance
0160	MO HealthNet Managed Care Organization Reimbursement Allowance
0161	Title XIX – Patient Placement
0164	State Treasurer's General Operation
0169	Child Support Enforcement Collections
0172	Missouri Technology Investment
0173	Microenterprise Loan
0174	Missouri Water Development
0176	General Revenue Reimbursements
0177	Missouri Humanities Council Trust
0196	Nursing Facility Federal Reimbursement Allowance
0198	Post Closure
0603	Attorney General's Court Costs
0666	Attorney General's Anti-Trust
0686	State Elections Subsidy
0692	State Legal Expense
0933	Home & Community-Based Developmental Disability
0935	Energy Futures Fund
0936	Criminal Nonsupport Court Resources
0938	Missouri Senior Cadets
0939	Line of Duty Compensation
0940	Persistence to Graduation
0941	Volunteer & Parents Incentive
0942	Mo Preschool Plus Grant Prog
0943	Teacher Choice Compensation
0945	Foster Care Dog Fund
0966	Mo Job Creation and Fed Match
Federal Funds:	
0104-0199	*(excluding Fund Numbers listed above and 0109, 0131, 0134, and 0170)*
0610	Department of Social Services Federal & Other Sources
0663	Missouri Disaster
0697	Abandoned Mined Reclamation
0782	Justice Assistance Grant Program
0948	Unemployment Compensation Administration
2000-2082	Federal Budget Stabilization
2200-2296	Federal Stimulus

This reporting is consistent with Missouri's Comprehensive Annual Financial Report.

STATE OF MISSOURI
NOTES TO THE APPROPRIATION ACTIVITY REPORT
APPROPRIATION YEAR 2010

Note 5 – General Revenue Fund

Operational results for the General Revenue Fund (Fund 0101) for fiscal year 2010 are as follows:

Revenues		
Taxes		$ 8,026,738,099
Licenses, Fees, and Permits		79,913,558
Sales, Services, Leases and Rentals		65,585,951
Contributions and Intergovernmental		9,545,526
Interest, Penalties, and Unclaimed Property		12,768,558
Refunds		23,108,720
Miscellaneous Revenues		26,033,495
	Subtotal	8,243,693,907
Transfers In		1,904,618,849
Total Revenues and Transfers In		10,148,312,756
Expenditures		
Personal Service		1,047,859,237
Expense and Equipment		335,936,738
Capital Improvements		2,402,748
Program Specific		2,998,774,662
Refunds		1,469,256,100
Court Order Desegregation Payments		9,000,000
	Subtotal	5,863,229,485
Transfers Out		4,410,737,909
Total Expenditures and Transfers Out		10,273,967,394
Excess Revenues and Transfers In		$ (125,654,638)

Note 6 – Refunds

In fiscal year 2010, refunds in the amount of $1,548,000,069 for all funds and $1,469,256,100 for the general revenue funds are reported on a separate line on page 3 and page 5 of this report. Refunds are reported as program specific expenditures on all remaining pages.

Note 7 – Debt Service

Debt Service includes payments made by the Office of Administration for the General Obligation bonds, the Board of Public Building Bonds, and certain capital lease payments. Other debt payments are reported as operating costs of the department which pays them.

Form 8 (formerly Form 4)

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

Dates of State Expenditure Period: From: 7/1/2009 To: 6/30/2010

	Source of Funds					
Activity	**A.SAPT Block Grant FY 2009 Award (Spent)**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 18,965,998	$ 31,425,345	$ 10,847,344	$ 36,731,605	$	$
Primary Prevention	$ 5,881,602		$ 3,505,303	$ 891,229	$	$
Tuberculosis Services	$ 4,244	$ 18,338	$ 934	$ 11,939	$	$
HIV Early Intervention Services	$	$	$	$	$	$
Administration: Excluding Program/Provider	$ 1,306,614		$ 1,780,310	$ 1,360,469	$	$
Column Total	**$26,158,458**	**$31,443,683**	**$16,133,891**	**$38,995,242**	**$0**	**$0**

***Prevention other than Primary Prevention**

Form 8ab (formerly Form 4ab)

Form 8a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2009	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 679,817	$ 319,558	$ 87,966	$	$
Education	$ 2,318,250	$ 525,933	$ 132,475	$	$
Alternatives	$ 323,494	$	$ 4,452	$	$
Problem Identification & Referral	$ 46,051	$	$ 1,031	$	$
Community Based Process	$ 1,240,204	$ 256,828	$ 228,344	$	$
Environmental	$ 469,638	$ 83,073	$ 64,425	$	$
Other	$ 408,087	$ 2,319,911	$ 63,299	$	$
Section 1926 - Tobacco	$ 396,061	$	$ 309,237	$	$
Column Total	**$5,881,602**	**$3,505,303**	**$891,229**	**$0**	**$0**

Form 8b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2009	Other Federal	State Funds	Local Funds	Other
Universal Direct	$ 3,055,767	$ 38,295	$ 226,377	$	$
Universal Indirect	$ 806,672	$ 895,629	$ 539,373	$	$
Selective	$ 2,019,163	$ 2,571,379	$ 125,479	$	$
Indicated	$	$	$	$	$
Column Total	**$5,881,602**	**$3,505,303**	**$891,229**	**$0**	**$0**

Form 8c (formerly Form 4c)

Resource Development Expenditure Checklist

Did your State fund resource development activities from the FY 2009 SAPT Block Grant?
(•) Yes ( ) No

Expenditures on Resource Development Activities are: (•) Actual ( ) Estimated				
Activity	**Column 1 Treatment**	**Column 2 Prevention**	**Column 3 Additional Combined**	**Total**
Planning, Coordination and Needs Assessment	$ 344,234	$	$	$ 344,234
Quality Assurance	$	$	$	$ 0
Training (post-employment)	$ 16,667	$	$	$ 16,667
Education (pre-employment)	$	$	$	$ 0
Program Development	$ 354,159	$	$ 9,968	$ 364,127
Research and Evaluation	$ 274,179	$	$	$ 274,179
Information Systems	$	$	$	$ 0
Column Total	**$989,239**	**$0**	**$9,968**	**$999,207**

Form 9 (formerly Form 6)

SUBSTANCE ABUSE ENTITY INVENTORY

				FISCAL YEAR 2009			
1. Entity Number	**2. I-SATS ID** [X] if no I-SATS ID	**3. Area Served**	**4. State Funds** (Spent during State expenditure period)	**5. SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services(other than primary prevention)**	**5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children**	**6. SAPT Block Grant Funds for Primary Prevention**	**7. SAPT Block Grant Funds for Early Intervention Services for HIV** (if applicable)
002	X	Northwest Region	$0	$681	$0	$0	
008	X	Central Region	$652,147	$130,269	$0	$596,387	
040	X	Central Region	$10,270	$0	$0	$0	
047	X	Southeast Region	$14,144	$0	$0	$0	
048	MO101631	Southwest Region	$0	$92	$0	$0	
051	X	Southeast Region	$4,286	$0	$0	$0	
054	X	Southwest Region	$1,546	$0	$0	$0	
055	MO101673	Southeast Region	$396,321	$371,793	$0	$0	
065	X	Central Region	$0	$0	$0	$32	
071	X	Southwest Region	$1,272	$0	$0	$0	
072	X	Statewide (optional)	$103,381	$0	$0	$0	
075	X	Central Region	$5,119	$0	$0	$0	
077	X	Central Region	$3,238	$0	$0	$0	
090	MO901642	Eastern	$32,801	$37,280	$0	$0	

090	MO901042	Region					
152	X	Eastern Region	$173,837	$0	$0	$662,382	
171	X	Northwest Region	$58,346	$0	$0	$292,244	
173	MO903788	Eastern Region	$477,079	$317,424	$14,069	$0	
183	MO100716	Northwest Region	$0	$792,087	$0	$0	
185	MO105152	Northwest Region	$13,646	$0	$0	$87,178	
189	MO100591	Eastern Region	$900,188	$79,470	$51,088	$0	
201	MO101433	Eastern Region	$1,457,839	$0	$0	$0	
207	MO101031	Southwest Region	$14,286	$0	$0	$0	
226	MO101755	Northwest Region	$140,143	$7,744	$0	$0	
238	MO102027	Eastern Region	$85,806	$1,628	$0	$0	
239	MO101987	Eastern Region	$58,946	$7,253	$0	$0	
249	MO100736	Eastern Region	$32,924	$2,250	$0	$0	
262	MO102928	Eastern Region	$1,312,600	$4,281	$0	$0	
267	X	Statewide (optional)	$0	$229,875	$0	$727,891	
269	MO105087	Eastern Region	$0	$825,465	$0	$0	
274	X	Southwest Region	$46,775	$0	$0	$0	
276	MO100849	Southwest Region	$224,595	$429,882	$0	$0	
282	MO101775	Northwest Region	$37,447	$0	$0	$0	
287	X	Statewide (optional)	$7,870	$0	$0	$0	
288	MO101774	Southeast Region	$17,928	$0	$0	$0	
312	MO101560	Southwest Region	$274,862	$41,616	$13,929	$0	
315	MO100687	Eastern Region	$35,502	$0	$0	$0	
318	MO301603	Eastern Region	$0	$713,125	$0	$0	

401	X	Statewide (optional)	$0	$7,222	$0	$0	
402	X	Statewide (optional)	$0	$2,746	$0	$0	
403	X	Statewide (optional)	$0	$29,890	$0	$0	
405	X	Statewide (optional)	$0	$137,950	$0	$652,581	
406	X	Eastern Region	$0	$0	$0	$34,814	
408	X	Southwest Region	$0	$0	$0	$259,138	
411	X	Eastern Region	$0	$0	$0	$79,903	
412	X	Eastern Region	$0	$0	$0	$144,334	
413	X	Statewide (optional)	$0	$0	$0	$174,070	
414	X	Southeast Region	$0	$0	$0	$72,340	
416	X	Statewide (optional)	$0	$0	$0	$309,810	
417	X	Southeast Region	$26,675	$0	$0	$109,851	
418	X	Southeast Region	$26,416	$0	$0	$76,101	
420	X	Southwest Region	$52,565	$0	$0	$306,168	
423	X	Statewide (optional)	$24,421	$0	$0	$0	
430	X	Southwest Region	$15,903	$0	$0	$0	
431	X	Statewide (optional)	$53,074	$0	$0	$0	
433	X	Northwest Region	$191,578	$0	$0	$0	
638	MO100667	Northwest Region	$344,953	$737,918	$0	$0	
037a	MO750593	Southwest Region	$451,086	$530,195	$0	$0	
037d	MO101452	Southwest Region	$32,156	$0	$0	$0	
037e	MO101553	Southwest Region	$35,026	$0	$0	$0	
043a	MO902004	Southwest Region	$243,505	$11,487	$0	$182,049	
		Southwest	$37,841	$0	$0	$0	

043d	MO101556	Southwest Region	$37,841	$0	$0	$0	
045a	MO105244	Northwest Region	$753,525	$696,656	$0	$0	
045c	MO902608	Northwest Region	$74,965	$16,427	$0	$0	
045d	MO902673	Northwest Region	$29,440	$14,697	$0	$0	
045e	MO101047	Northwest Region	$0	$135	$0	$0	
045f	MO101048	Northwest Region	$0	$645	$0	$0	
045g	MO101532	Northwest Region	$7,137	$45,099	$0	$0	
045h	MO101759	Northwest Region	$14,819	$0	$0	$0	
048a	MO101028	Southwest Region	$32,819	$36,285	$0	$0	
049a	MO106614	Central Region	$40,502	$361	$0	$36	
049aa	MO106317	Central Region	$108	$0	$0	$0	
049ab	MO101447	Northwest Region	$449	$0	$0	$0	
049ac	MO101448	Central Region	$13,579	$0	$0	$0	
049ad	MO101499	Central Region	$108	$792	$0	$80	
049ae	MO101509	Central Region	$10,830	$0	$0	$0	
049b	MO106218	Southeast Region	$169,235	$15,363	$0	$1,549	
049c	MO103801	Southwest Region	$21,968	$24,256	$0	$2,446	
049e	MO901527	Southwest Region	$678,907	$367,802	$0	$37,087	
049f	MO106267	Central Region	$100,495	$9,368	$0	$945	
049g	MO106309	Southwest Region	$57,903	$2,643	$0	$266	
049h	MO103272	Northwest Region	$147	$53	$0	$5	
049i	MO106242	Southwest Region	$19,477	$25,725	$0	$2,594	
049j	MO100404	Southeast Region	$21,129	$1,622	$0	$164	
049k	MO103207	Central	$142,543	$5,201	$0	$524	

049k	MO105207	Region					
049l	MO105814	Central Region	$5,053	$176	$0	$18	
049o	MO103124	Northwest Region	$38,434	$13,056	$0	$1,317	
049p	MO103280	Northwest Region	$64,568	$51,970	$0	$5,240	
049q	MO901543	Northwest Region	$264,024	$280,761	$0	$28,310	
049r	MO103231	Northwest Region	$30,694	$19,011	$0	$1,917	
049s	MO103215	Northwest Region	$52	$113	$0	$11	
049t	MO100321	Central Region	$45,895	$216	$0	$22	
049v	MO106283	Central Region	$8,282	$0	$0	$0	
049w	MO103918	Southwest Region	$24,173	$18,972	$0	$1,913	
049x	MO100865	Northwest Region	$28,054	$17,334	$0	$1,748	
049z	MO100808	Northwest Region	$41,350	$28,478	$0	$2,871	
052a	MO103389	Southwest Region	$54,385	$10,451	$0	$0	
052d	MO901501	Southwest Region	$364,392	$370,035	$0	$0	
052e	MO100869	Southwest Region	$9,730	$810	$0	$0	
052f	MO100650	Southwest Region	$136,105	$50,639	$0	$0	
052g	MO100787	Southwest Region	$37,521	$85,242	$0	$0	
052i	MO101769	Southwest Region	$29,702	$0	$0	$0	
053a	MO102159	Central Region	$566,989	$658,577	$0	$0	
055a	MO903911	Southeast Region	$96,442	$0	$0	$0	
055aa	MO100774	Southeast Region	$7,472	$12,105	$0	$0	
055ab	MO101135	Southeast Region	$26,035	$0	$0	$0	
055ac	MO101566	Southeast Region	$13,437	$5,219	$0	$0	
055ad	MO101587	Southeast Region	$184	$0	$0	$0	

055b	MO103785	Southeast Region	$23,187	$38,677	$0	$0	
055c	MO104593	Southeast Region	$112,360	$81,763	$0	$0	
055e	MO100850	Southeast Region	$6,309	$0	$0	$0	
055f	MO100848	Southeast Region	$8,548	$0	$0	$0	
055g	MO104791	Southeast Region	$19,595	$0	$0	$0	
055h	MO100859	Southeast Region	$35,388	$23,226	$0	$0	
055l	MO100929	Southeast Region	$1,429	$0	$0	$0	
055o	MO100770	Southeast Region	$54,822	$28,673	$0	$0	
055p	MO100858	Eastern Region	$15,046	$11	$0	$0	
055q	MO100853	Southeast Region	$5,638	$0	$0	$0	
055u	MO105913	Southeast Region	$31,706	$28,707	$0	$0	
055w	MO100772	Southeast Region	$49,893	$40,322	$0	$0	
055x	MO100852	Southeast Region	$20,425	$0	$0	$0	
055y	MO100855	Southeast Region	$13,661	$0	$0	$0	
055z	MO100854	Southeast Region	$13,120	$0	$0	$0	
056a	MO101128	Southeast Region	$566,361	$67,975	$60,797	$16,443	
056ac	MO101227	Southeast Region	$212,708	$18,649	$0	$4,511	
056b	MO301793	Southeast Region	$545,258	$211,147	$20,853	$51,075	
056c	MO101391	Southeast Region	$8,257	$0	$0	$0	
056e	MO100620	Southeast Region	$12,509	$1,050	$0	$254	
056f	MO000041	Southeast Region	$221,803	$7,704	$0	$1,864	
056g	MO903598	Southeast Region	$95,593	$87,214	$0	$21,096	
056i	MO100649	Southeast Region	$13,426	$630	$630	$152	
		Southeast	$10,615	$220	$0	$53	

056j	MO100828	Southeast Region	$10,615	$220	$0	$55	
056k	MO101311	Southeast Region	$93,936	$4,812	$0	$1,164	
056l	MO105657	Southeast Region	$253	$41	$0	$10	
056m	MO105848	Southeast Region	$14,301	$16,326	$0	$3,949	
056n	MO750502	Southeast Region	$254,127	$369,307	$0	$89,331	
056o	MO101501	Southeast Region	$28,750	$0	$0	$0	
056o	MO101548	Southeast Region	$5,536	$0	$0	$0	
056q	MO101549	Southeast Region	$37,020	$0	$0	$0	
056r	MO101551	Southeast Region	$65,420	$0	$0	$0	
056s	MO101498	Southeast Region	$13,186	$0	$0	$0	
056t	MO105830	Southeast Region	$60	$0	$0	$0	
057d	MO100864	Northwest Region	$57,191	$25,148	$25,140	$0	
057e	MO101207	Northwest Region	$579,336	$64,213	$62,279	$0	
057f	MO104262	Northwest Region	$25,651	$4,431	$4,431	$0	
057g	MO101517	Northwest Region	$683,859	$29,706	$29,706	$0	
058a	MO100518	Northwest Region	$175,060	$255,431	$23,584	$0	
058b	MO301678	Northwest Region	$1,192,213	$361,165	$31,857	$0	
058d	MO100710	Northwest Region	$83	$198	$0	$0	
061a	MO101011	Central Region	$296,832	$278,966	$0	$0	
061c	MO106101	Central Region	$13,596	$22,354	$0	$0	
061d	MO750098	Central Region	$997,894	$503,044	$50,444	$0	
061e	MO106671	Central Region	$36,085	$37,131	$0	$0	
061i	MO100718	Central Region	$5,756	$11,302	$0	$0	
062a	MO902269	Central	$744,648	$19,258	$19,258	$5,481	

062a	MO902269	Region					
062b	MO100179	Central Region	$235,472	$321,136	$0	$91,392	
062c	MO105475	Central Region	$23,961	$16,412	$0	$4,671	
062d	MO750056	Central Region	$108,566	$107,261	$20,466	$30,525	
062e	MO100187	Central Region	$237,002	$56,949	$176	$16,207	
062i	MO105285	Central Region	$6,309	$19,108	$0	$5,438	
062j	MO100776	Central Region	$22,136	$9,213	$0	$2,622	
062k	MO100483	Central Region	$38,552	$354	$0	$101	
062l	MO102159	Central Region	$26,926	$59,556	$0	$16,949	
062n	MO103207	Central Region	$145	$0	$0	$0	
062n	MO100783	Central Region	$135	$5,203	$0	$1,481	
062q	MO100809	Central Region	$10,503	$2,044	$0	$582	
062r	MO100927	Central Region	$2,838	$1,269	$0	$361	
062s	MO106614	Central Region	$6,419	$12,640	$0	$3,597	
062t	MO101445	Central Region	$59,674	$0	$0	$0	
074a	MO103330	Northwest Region	$17,663	$213	$0	$0	
074b	MO103348	Southwest Region	$0	$25	$0	$0	
074c	MO100930	Southwest Region	$12,453	$60	$0	$0	
074d	MO103355	Southwest Region	$6,520	$342	$0	$0	
082a	MO901592	Eastern Region	$170,539	$165,617	$0	$0	
082b	MO103009	Eastern Region	$188,843	$61,550	$0	$0	
082d	MO102209	Eastern Region	$397,674	$311,610	$0	$0	
082e	MO101485	Eastern Region	$398	$0	$0	$0	
082f	MO101493	Eastern Region	$547	$1,278	$0	$0	

082g	MO101487	Eastern Region	$57,940	$46	$0	$0	
087a	MO106598	Northwest Region	$8,734	$44,539	$0	$14,521	
087b	MO903127	Northwest Region	$447,774	$422,119	$0	$137,621	
089b	MO101033	Eastern Region	$279,527	$563,710	$0	$0	
090a	MO101136	Eastern Region	$1,368,217	$561,626	$38,582	$0	
090b	MO101458	Eastern Region	$235,204	$85,425	$128	$0	
090c	MO106069	Eastern Region	$169,285	$83,041	$55	$0	
090e	MO102803	Eastern Region	$129,093	$35,837	$427	$0	
090g	MO100765	Eastern Region	$123,428	$185,956	$0	$0	
090h	MO100581	Eastern Region	$2,558	$5,298	$0	$0	
090i	MO100786	Eastern Region	$47,154	$218,731	$24,880	$0	
090j	MO101486	Eastern Region	$60,597	$14,737	$0	$0	
090k	MO101515	Eastern Region	$180,240	$134,596	$0	$0	
090l	MO100283	Eastern Region	$107,205	$0	$0	$0	
153aa	MO101389	Northwest Region	$52	$0	$0	$0	
153ab	MO101479	Northwest Region	$10,783	$9,482	$0	$1,704	
153ac	MO102019	Northwest Region	$304,998	$15,101	$0	$2,715	
153ad	MO100624	Northwest Region	$64,644	$2,008	$0	$361	
153ae	MO101407	Central Region	$5,060	$0	$0	$0	
153af	MO106093	Central Region	$35,230	$0	$0	$0	
153ag	MO101628	Eastern Region	$52,073	$0	$0	$0	
153ah	MO100922	Southwest Region	$131,190	$61,708	$0	$11,096	
153ai	MO101449	Eastern Region	$30,367	$0	$0	$0	
		Central	$106,095	$2,547	$0	$458	

153b	MO105723	Central Region	$100,095	$2,547	$0	$458	
153c	MO000024	Eastern Region	$600,807	$1,120,869	$0	$201,545	
153d	MO100567	Eastern Region	$30,994	$2,449	$0	$441	
153e	MO105715	Eastern Region	$272,450	$29,370	$0	$5,281	
153f	MO105046	Central Region	$92,598	$1,555	$0	$279	
153g	MO105780	Central Region	$11,111	$204	$0	$37	
153h	MO103942	Central Region	$81,222	$1,252	$0	$225	
153i	MO101797	Central Region	$93,166	$108,470	$0	$19,505	
153j	MO105038	Northwest Region	$75,010	$3,699	$0	$665	
153k	MO105210	Northwest Region	$30,392	$27,682	$0	$4,978	
153l	MO101169	Central Region	$844,094	$43,156	$0	$7,760	
153m	MO103892	Northwest Region	$32,626	$24,729	$0	$4,447	
153n	MO103900	Northwest Region	$265,292	$338,260	$0	$60,824	
153o	MO000025	Northwest Region	$270,943	$18,713	$0	$3,365	
153q	MO100668	Central Region	$393,137	$463,453	$0	$83,334	
153t	MO100768	Eastern Region	$293,527	$144,904	$0	$26,055	
153w	MO100503	Eastern Region	$7,406	$962	$0	$173	
153y	MO100871	Northwest Region	$0	$132	$0	$24	
153z	MO101388	Northwest Region	$4,729	$3,196	$0	$575	
154a	MO100526	Northwest Region	$114,665	$156,283	$0	$0	
154aa	MO101438	Southwest Region	$184,488	$455	$0	$0	
154ae	MO100288	Northwest Region	$78,812	$0	$0	$0	
154ag	MO101440	Northwest Region	$29,266	$0	$0	$0	
154al	X	Northwest	$7,260	$0	$0	$0	

154a	X	Region					
154b	MO301785	Northwest Region	$224,034	$274,913	$0	$0	
154c	MO101441	Northwest Region	$259,807	$260,900	$0	$0	
154k	MO100870	Northwest Region	$272,080	$0	$0	$0	
154o	MO101067	Northwest Region	$39,153	$40,992	$0	$0	
154p	MO101477	Southwest Region	$26,677	$0	$0	$0	
154q	MO101480	Southwest Region	$39,398	$0	$0	$0	
154r	MO101483	Southwest Region	$54,679	$0	$0	$0	
154s	MO101489	Southwest Region	$25,336	$0	$0	$0	
154t	MO101439	Southwest Region	$18,487	$0	$0	$0	
154u	MO101368	Northwest Region	$110,492	$48,085	$0	$0	
154v	MO101478	Northwest Region	$700,471	$0	$0	$0	
154w	MO101481	Southwest Region	$43,212	$0	$0	$0	
154x	MO101442	Southwest Region	$20,852	$0	$0	$0	
154y	MO101437	Northwest Region	$19,981	$0	$0	$0	
154z	MO101484	Southwest Region	$22,992	$0	$0	$0	
156a	MO100264	Southwest Region	$1,407	$258	$258	$0	
156b	MO101029	Southwest Region	$539,063	$59,112	$59,112	$0	
156c	MO100287	Southwest Region	$47,334	$2,165	$2,165	$0	
158a	MO000022	Southeast Region	$299,722	$267,955	$0	$18,571	
158b	MO103157	Southeast Region	$57,052	$26,771	$0	$1,855	
158c	MO902319	Southeast Region	$355,904	$159,688	$0	$11,067	
158d	MO105095	Southeast Region	$84,573	$36,796	$0	$2,550	
158e	MO102571	Southeast Region	$108,729	$50,408	$0	$3,494	

158f	MO106705	Southeast Region	$189,165	$76,858	$0	$5,327	
158g	MO903853	Southeast Region	$202,975	$108,624	$0	$7,528	
158h	MO000021	Southeast Region	$177,769	$57,384	$0	$3,977	
158j	MO103165	Southeast Region	$59,351	$6,549	$0	$454	
158k	MO103140	Southeast Region	$92,566	$26,428	$0	$1,832	
158l	MO100928	Southeast Region	$45,726	$13,252	$0	$918	
158m	MO903259	Southeast Region	$2,385	$113,908	$0	$7,894	
158n	MO100730	Southeast Region	$115,279	$17,281	$0	$1,198	
158o	MO101468	Southeast Region	$22,099	$4,067	$0	$282	
158p	MO101451	Southeast Region	$106,627	$0	$0	$0	
158q	MO101469	Southeast Region	$40,067	$9,622	$0	$667	
158r	MO101471	Southeast Region	$29,495	$0	$0	$0	
158s	MO101470	Southeast Region	$29,043	$5,094	$0	$353	
158t	MO101518	Southeast Region	$33,657	$0	$0	$0	
173a	MO101558	Eastern Region	$236,874	$60,803	$60,803	$0	
188a	MO100922	Southwest Region	$76,350	$2,963	$0	$0	
207b	MO101751	Southwest Region	$7,135	$0	$0	$0	
208a	MO103850	Eastern Region	$146,699	$13,942	$0	$0	
208b	MO101761	Eastern Region	$55,182	$0	$0	$0	
209c	MO101773	Southwest Region	$79,170	$0	$0	$0	
210a	MO101623	Eastern Region	$93,994	$5,411	$0	$0	
210b	MO103462	Eastern Region	$75,236	$4,356	$0	$0	
210c	MO106077	Eastern Region	$95,030	$5,276	$0	$0	
		Eastern	$73,558	$4,252	$0	$0	

210d	MO103884	Eastern Region	$75,558	$4,252	$0	$0	
210e	MO100713	Eastern Region	$4,716	$0	$0	$0	
210g	MO101754	Eastern Region	$15,931	$0	$0	$0	
210h	MO101756	Eastern Region	$14,207	$0	$0	$0	
210i	MO101757	Eastern Region	$29,756	$0	$0	$0	
210j	MO101758	Eastern Region	$18,056	$0	$0	$0	
210k	MO101533	Eastern Region	$84,900	$4,902	$0	$0	
210n	X	Eastern Region	$12,815	$0	$0	$0	
210o	X	Eastern Region	$11,127	$0	$0	$0	
216a	MO101743	Northwest Region	$978	$0	$0	$0	
216b	MO101744	Northwest Region	$14,070	$0	$0	$0	
217a	MO101745	Northwest Region	$41,856	$0	$0	$0	
217b	MO101746	Northwest Region	$39,683	$0	$0	$0	
226a	MO101187	Northwest Region	$21,354	$856	$0	$0	
226b	MO101562	Northwest Region	$289	$0	$0	$0	
227a	MO101772	Eastern Region	$40,456	$0	$0	$0	
231a	MO101776	Central Region	$77,969	$0	$0	$0	
231b	MO101779	Southwest Region	$31,700	$0	$0	$0	
238a	MO101765	Southeast Region	$12,221	$0	$0	$0	
249c	MO105426	Eastern Region	$112,689	$7,082	$0	$0	
249e	MO105459	Eastern Region	$27,603	$1,625	$0	$0	
249k	MO101347	Eastern Region	$32,317	$1,924	$0	$0	
249l	MO105418	Eastern Region	$40,309	$1,106	$0	$0	
249m	MO102035	Eastern	$114,302	$8,400	$0	$0	

249m	MO102035	Region					
249n	MO101269	Eastern Region	$13,878	$597	$0	$0	
249o	MO101747	Eastern Region	$26,181	$0	$0	$0	
249p	MO101749	Eastern Region	$149,608	$0	$0	$0	
249q	MO101750	Eastern Region	$39,224	$0	$0	$0	
250a	MO100729	Northwest Region	$39,956	$7,285	$0	$0	
250b	MO102068	Northwest Region	$327,041	$22,764	$0	$0	
250c	MO103470	Northwest Region	$51,345	$6,499	$0	$0	
250d	MO105251	Northwest Region	$74,078	$11,839	$0	$0	
250e	MO105988	Northwest Region	$64,857	$6,104	$0	$0	
252a	MO101543	Southeast Region	$9,658	$0	$0	$0	
252b	MO101737	Southeast Region	$80,072	$0	$0	$0	
255a	MO103504	Northwest Region	$376,516	$0	$0	$0	
275a	MO103868	Central Region	$52,117	$0	$0	$0	
275b	MO100711	Central Region	$89,558	$8,188	$0	$0	
277a	MO100719	Southeast Region	$3,584	$0	$0	$0	
277b	MO101760	Southeast Region	$20,484	$0	$0	$0	
312a	MO903879	Southwest Region	$675,438	$37,043	$37,043	$0	
315a	MO100688	Eastern Region	$133,881	$17,056	$0	$0	
315c	MO101742	Eastern Region	$52,524	$0	$0	$0	
422a	MO105541	Southwest Region	$35,966	$0	$0	$0	
428a	MO101739	Central Region	$46,464	$0	$0	$0	
428b	MO101740	Central Region	$39,604	$0	$0	$0	
Totals:			**$37,634,774**	**$18,970,242**	**$652,160**	**$5,881,601**	**$0**

Form 9 includes all entities receiving SAPT BG funds for services for pregnant women and women with dependent children are listed in Attachment B. Some entities will be satellite sites of a parent organization.

PROVIDER ADDRESS TABLE

Provider ID	Description	Provider Address
002	NORTHWEST MO PSYCHIATRIC REHAB CENTER	3505 Frederick St. Joseph, MO 64506 816-387-2329
008	CENTRAL OFFICE	1706 E. Elm Street Jefferson City, MO 65101 573-751-4942
040	Central Missouri Community Action	807 B North Providence Rd Columbia, MO 65203
047	Delta Area Economic Opportunity Corp.	99 Skyview Rd Portageville, MO 63873 573-379-3851
051	East Missouri Action Agency	403 Parkway Dr Park Hills, MO 63601 573-431-5191
052	Ozark Center	3006 McClelland Blvd. Joplin, MO 64803 417-347-7600
054	Economic Security Corp	302 South Joplin Ave Joplin, MO 64802 417-781-0352
065	L-1 Enrollment Services	1650 Wabash Ave - Suite D Springfield, IL 63704 217-793-2080
071	Missouri Ozarks Community	306 South Pine Richland, MO 65556 573-765-3263
072	Missouri Police Chief's Charitable Foundation	1001 East High St Jefferson City, MO 65101 573-636-5444
075	Missouri Valley Community Action Agency	1415 South Odell Marshall, MO 65340 660-886-7476
077	North East Community Action	16 N Court St Bowling Green, MO 63334 573-324-5062
152	NATIONAL COUNCIL ON ALCOHOLISM & DRUG ABUSE - ST LOUIS AREA INC	8790 Manchester Road St. Louis, MO 63144 314-962-3456
	First Call Alcohol/Drug	633 E. 63rd Street

171	Alcohol/Drug Prevention & Recovery	Kansas City, MO 64110 816-361-5900
267	MISSOURI ASSOCIATION OF COMMUNITY TASK FORCES	428 E. Capitol Avenue Second Floor Jefferson City, MO 65101 573-635-6669
274	ALCOHOL DRUG CONSULTANTS	1736 East Sunshine Suite 214 Springfield, MO 65804 417-848-4565
282	ST JOSEPH SAFETY & HEALTH COUNCIL	118 South Fifth Street (Lower Level) St. Joseph, MO 64501 816-233-3330
287	DEAF HOPE	PO Box 14441 Shawnee Mission, KS 66215 913-281-4875
288	SOUTH CENTRAL MO CITIZEN'S ADVISORY	1580 Imperial Center West Plains, MO 65775 417-257-7568
315	Assessment & Counseling Solutions-Kirkwood	1200 South Kirkwood Rd. Kirkwood, MO 63122 314-849-2800
401	COMMUNITY HOUSING NETWORK INC	2600 East 12th Street Kansas City, MO 64127 816-482-5744
402	COVINGTON AND BURLING	1201 Pennsylvania Ave NW PO Box 7566 Washington, DC 20044 202-662-5410
403	OXFORD HOUSE INC.	1010 Wayne Avenue Suite 300 Silver Spring, MD 20910 301-587-2916
405	UNIVERSITY OF MO - COLUMBIA	Sponsored Programs Admin 310 Jesse Hall Columbia, MO 65211 573-882-9587
406	BIG BROTHERS BIG SISTERS	501 North Grand Blvd St. Louis, MO 63103 314-361-5900
408	COMMUNITY PARTNERSHIP OF OZARKS	330 N. Jefferson Springfield, MO 65806 417-888-2020
411	DISCOVERING OPTIONS	909 Purdue Avenue St. Louis, MO 63130 314-721-8116
	FRIENDS WITH A	5622 Delmar Suite 102E

412	FRIENDS WITH A BETTER PLAN	St. Louis, MO 63112 314-361-2371
413	LEAD INSTITUTE THE	2502 West Ash Columbia, MO 65203 573-817-2400
414	LINCOLN UNIVERSITY	Business & Finance 306 Young Hall PO Box 29 Jefferson City, MO 65102 573-681-5058
416	MO ALLIANCE OF BOYS/GIRLS CLUB	1460 Bee Creek Road Branson, MO 65616 417-335-2089
417	PREVENTION CONSULTANTS OF MO	104 East 7th Street Rolla, MO 65401 573-368-4755
418	SOUTHEAST MO STATE UNIVERSITY	One University Plaza MS 3000 Cape Girardeau, MO 63701 573-651-2018
420	UNITED WAY OF THE OZARKS	320 N. Jefferson Springfield, MO 65806 417-863-7700
423	SAVE INC.	PO Box 45301 Kansas City, MO 64171 816-531-8340
430	OZARKS AREA COMMUNITY ACTION	215 South Barnes Avenue Springfield, MO 65802 417-864-3492
431	OFFICE OF STATE COURTS ADMINISTRATION	2112 Industrial Drive PO Box 104480 Jefferson City, MO 65110 573-751-4377
433	Amethyst Place Kansas City	1102 Benton , 1 N Kansas City, MO 64127 816-231-8782
154al	KCCC – Independence (N. Main)	103 North Main St. Suite 102 Independence, MO 64050
210n	EMASS – Maryland Heights (Best Western)	Best Western Westport Plaza 2434 Old Dorsett Rd. Maryland Heights, MO 63043
210o	EMASS – Wentzville (Holiday Inn)	Holiday Inn 900 Corporate Pkwy Wentzville, MO 63385
238a	Meramec Recovery Center - Dexter	500 East Hwy. 100 Washington, MO 63090 800-886-5860

Form 9a (formerly Form 6a)

Prevention Strategy Report

Column A (Risks)	Column B(Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	4
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	13
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22

	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
Drop-Outs [3]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
Violent and Delinquent Behavior [4]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences,	22

	meetings, seminars [7]	
	Information lines/Hot lines [8]	1
	Education programs for youth groups [14]	13
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	13
Mental Health Problems [5]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	4
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18

	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	13
Economically Disadvantaged [6]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	4
	Ongoing classroom and/or small group sessions [12]	8
	Mentors [15]	5
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	8
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13

	Accessing services and funding [45]	13
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	13
Physically Disabled [7]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Information lines/Hot lines [8]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
Abuse Victims [8]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Information lines/Hot lines [8]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13

Already Using Substances [9]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Information lines/Hot lines [8]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
Homeless and/or Run away Youth [10]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Multi-agency coordination and collaboration/coalition [43]	13

Form 10a (formerly Form 7a)

TREATMENT UTILIZATION MATRIX

Dates of State Expenditure Period: From: 7/1/2009 To: 6/30/2010

	Number of Admissions ≥ Number of Persons		Costs per Person		
Level of Care	**A. Number of Admissions**	**B. Number of Persons**	**C. Mean Cost of Services**	**D. Median Cost of Services**	**E. Standard Deviation of Cost**
Detoxification (24-Hour Care)					
Hospital Inpatient	173	162	$ 1959	$ 1356	$ 2074
Free-standing Residential	8016	5772	$ 466	$ 276	$ 678
Rehabilitation / Residential					
Hospital Inpatient	0		$	$	$
Short-term (up to 30 days)	16827	13217	$ 1696	$ 1618	$ 1609
Long-term (over 30 days)	0		$	$	$
Ambulatory (Outpatient)					
Outpatient	18531	16123	$ 550	$ 463	$ 525
Intensive Outpatient	21530	16364	$ 805	$ 487	$ 1037
Detoxification	0		$	$	$
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy	508	314	$ 1069	$ 431	$ 1281

Summing column "B. Number of Persons" will not result in an unduplicated count of persons admitted to treatment because an individual may be admitted to more than one type of level of care during the course of the fiscal year. In addition, number of persons admitted to treatment is not the same as number served because some individuals will have been admitted prior to the start of the fiscal year but will receive serves in the reportable fiscal year. Form 10b (formerly Form 7b) provides an unduplicated count of number served.

Form 10b (formerly Form 7b)

Number of Persons Served (Unduplicated Count) for alcohol and other drug use in state-funded services by age, sex, and race/ethnicity

Age	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	1,970	936	497	347	63	1	0	0	0	0	2	52	21	42	9	1,341	577	37	15
2. 18-24	6,483	3,630	1,514	834	236	6	0	5	3	6	6	108	50	65	20	4,556	1,787	98	42
3. 25-44	17,315	8,853	4,145	2,772	883	12	4	19	6	44	14	228	121	156	58	11,832	5,139	252	92
4. 45-64	6,798	3,480	1,133	1,595	374	1	1	9	2	14	2	93	39	51	4	5,175	1,545	68	10
5. 65 and over	156	102	16	28	4	0	0	0	0	0	0	4	1	1	0	132	21	3	0
6. Total	32,722	17,001	7,305	5,576	1,560	20	5	33	11	64	24	485	232	315	91	23,036	9,069	458	159
7. Pregnant Women	398		286		86		0		0		2		18		6		379		19

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers? (•) Yes ( ) No

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period. 12,821

Numbers of Persons Served outside of the levels of care described in Form 10a. 12,652

Persons served outside of the the levels of care include those individuals who were received non-treatment services including recovery supports, Department of Corrections education, Weekend Intervention Program, or early intervention services.

Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. §300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. §300x-24(d) (See 45 C.F.R. §96.122(f)(5)(ii)(A)(B)(C)).

Description of Calculations:

TB SERVICES

The Division of Alcohol and Drug Abuse works in cooperation with the Missouri Department of Corrections, Missouri Department of Health and Senior Services, and the Missouri Department of Social Services, MO HealthNet Division (Medicaid) to collect the information required to report the statewide non-federal cost of Tuberculosis Services provided to citizens of Missouri, as well as to the substance abusers in treatment in Missouri. The statewide expenditures for Tuberculosis Services to substance abusers in treatment have been calculated with the following methodology:

The Department of Corrections provides aggregated costs of TB services to inmates in correctional facilities, and associated costs to those inmates in institutional substance abuse treatment programs.

The Department of Health and Senior Services provides aggregated costs of the number of clients treated for TB by local health departments. In addition, non-federal cost of the TB tests performed at local health departments is computed for clients referred from ADA funded treatment programs.

The Department of Social Services provides statewide expenditures for claims with TB diagnosis codes per the Missouri Medicaid Management Information System. The State Medicaid expenditures for TB treatment provided by ADA funded programs per the Department of Mental Health Customer Information Management, Outcomes, & Reporting (CIMOR) system are a subset of the information received from Medical Services and represent the percent of expenditures that were spent on substance abusers in treatment.

The final component of the TB cost determination is from the CIMOR system which captures services delivered to clients by service code. The payments for these non-Medicaid TB services were summed and segregated by funding source (Non-Federal or State Funds).

Table 1 Methodology for Determining the Cost of Tuberculosis Services Provided to Substance Abusers in Treatment.

A	B	C	D
Agency	**Total of All State funds spent on TB services**	**% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment**	**Total State Funds Spent on Clients who were Substance Abusers in Treatment**
ADA non-Medicaid	State non-Medicaid expenditures for TB treatment provided by ADA funded programs per the DMH (CIMOR) data system	Column D / Column B	State non-Medicaid expenditures for TB treatment provided by ADA funded programs per the DMH (CIMOR) data system
Medicaid	State Medicaid expenditures for claims with TB diagnosis codes per the Missouri Medicaid Management System	Column D / Column B	State Medicaid expenditures for TB treatment provided by ADA funded programs per the DMH (CIMOR) data system

A	B	C	D
Agency	**Total of All State funds spent on TB services**	**% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment**	**Total State Funds Spent on Clients who were Substance Abusers in Treatment**
	(MMIS)		
Department of Corrections (DOC)	State expenditures for TB services provided in correctional facilities. Computed as the total number of inmates multiplied by the average TB treatment cost per day multiplied by average length of incarceration per inmate	Column D / Column B	The number of inmates receiving substance abuse treatment in correctional facilities multiplied by the average TB treatment cost per day multiplied by the average length of incarceration per inmate
Department of Health and Senior Services (DHSS)	Total State expenditures for TB services per DHSS	Column D / Column B	The number of clients referred from ADA funded treatment programs to local health departments for TB testing multiplied by average State expenditures for TB testing -plus- The number of clients treated for TB by local health departments multiplied by average State expenditures for TB treatment
Total	Sum of Rows Above	Sum of Rows Above	Sum of Rows Above

PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN

The Division used the following method to calculate the amounts for the base and subsequent years for services to pregnant women and women with dependent children:

For the base year 1992, all payments for services to women at programs meeting the requirements of Section 1922© and Section 96.124 (e) were summed and segregated by funding source (Federal Block Grant and Non-Federal or State Funds). The required base expenditures were calculated as $7,728,020.

The Department of Mental Health CIMOR fee-for-service payment system uses detailed coding to capture services delivered to pregnant women and women with dependent children by procedure code. The total expenditures on these qualified programs were $9,357,208 for SFY 2011 which exceeds the required base expenditure.

SSA (MOE TABLE I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2007) + B2(2008) / 2 (C)
SFY 2009 (1)	**$48,801,203**	**$49,305,555**
SFY 2010 (2)	**$49,809,906**	
SFY 2011 (3)	$ 47,926,531	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

FY 2009 (•) Yes ( ) No
FY 2010 (•) Yes ( ) No
FY 2011 (•) Yes ( ) No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA (mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2011 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

( ) Yes (•) No If yes, specify the amount and the State fiscal year: $, (SFY)

Did the State include these funds in previous year MOE calculations?

( ) Yes (•) No

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations? (Date)

The state is in the process of submitting a request to exclude the $163,554 expenditures for 6776 Bridgeway lease that existed only in FY 2011.

TB (MOE TABLE II)

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)	Average of Columns C1 and C2 C1 + C2 -------- 2 (D)
SFY 1991 (1)	$ 421,670	0.06 %	$ 253	$ 1,265
SFY 1992 (2)	$ 455,117	0.50 %	$ 2,276	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)
SFY 2011 (3)	$ 353,032	11.085890 %	$ 39,137

HIV (MOE TABLE III)

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1 + A2 --- 2 (B)
SFY 1993 (1)	$ 298,242	$ 301,434
SFY 1994 (2)	$ 304,625	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2011 (3)	$

* Provided to substance abusers at the site at which they receive substance abuse treatment

Missouri is not an HIV designated state.

Womens (MOE TABLE IV)

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

Period	Total Women's Base (A)	Total Expenditures (B)
1994	**$7,728,020**	
2009		**$10,238,872**
2010		**$9,661,268**
2011		$ 9,357,208

Enter the amount the State plans to expend in FY 2012 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $ 9,357,208

Form T1

Form T1 was pre-populated with the following Data Source: Discharges in CY 2010

EMPLOYMENT/EDUCATION STATUS (From Admission to Discharge)

Short-term Residential(SR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients employed (full-time and part-time) or student [numerator]	**2,846**	**2,853**
Total number of clients with non-missing values on employment\student status [denominator]	**11,312**	**11,312**
Percent of clients employed (full-time and part-time) or student	**25.2%**	**25.2%**

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**9,679**
Number of CY 2010 discharges submitted:	**12,325**
Number of CY 2010 discharges linked to an admission:	**12,204**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**11,958**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**11,312**
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Long-term Residential(LR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients employed (full-time and part-time) or student [numerator]		
Total number of clients with non-missing values on employment\student status [denominator]		
Percent of clients employed (full-time and part-time) or student		

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**0**
Number of CY 2010 discharges submitted:	**0**
Number of CY 2010 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]

Intensive Outpatient (IO)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients employed (full-time and part-time) or student [numerator]	**6,146**	**6,965**
Total number of clients with non-missing values on employment\student status [denominator]	**19,269**	**19,269**
Percent of clients employed (full-time and part-time) or student	**31.9%**	**36.1%**

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**18,640**
Number of CY 2010 discharges submitted:	**23,684**
Number of CY 2010 discharges linked to an admission:	**23,274**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**22,150**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**19,269**
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Outpatient (OP)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients employed (full-time and part-time) or student [numerator]	**7,541**	**8,214**
Total number of clients with non-missing values on employment\student status [denominator]	**15,580**	**15,580**
Percent of clients employed (full-time and part-time) or student	**48.4%**	**52.7%**

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**11,802**
Number of CY 2010 discharges submitted:	**18,173**
Number of CY 2010 discharges linked to an admission:	**17,931**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**17,376**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**15,580**
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file	

[Records received through 12/7/2011]

Form T2

Form T2 was pre-populated with the following Data Source: Discharges in CY 2010

STABLE HOUSING SITUATION (From Admission to Discharge)

Short-term Residential(SR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with stable housing [numerator]	**9,848**	**10,141**
Total number of clients with non-missing values on living arrangements [denominator]	**10,730**	**10,730**
Percent of clients with stable housing	**91.8%**	**94.5%**

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**9,679**
Number of CY 2010 discharges submitted:	**12,325**
Number of CY 2010 discharges linked to an admission:	**12,204**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**11,958**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**10,730**
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]	

Long-term Residential(LR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with stable housing [numerator]		
Total number of clients with non-missing values on living arrangements [denominator]		
Percent of clients with stable housing		

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**0**
Number of CY 2010 discharges submitted:	**0**
Number of CY 2010 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**0**
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]	

Intensive Outpatient (IO)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with stable housing [numerator]	**17,498**	**17,612**
Total number of clients with non-missing values on living arrangements [denominator]	**18,190**	**18,190**
Percent of clients with stable housing	**96.2%**	**96.8%**

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**18,640**
Number of CY 2010 discharges submitted:	**23,686**
Number of CY 2010 discharges linked to an admission:	**23,275**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**22,151**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**18,190**
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]	

Outpatient (OP)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with stable housing [numerator]	**14,697**	**14,761**
Total number of clients with non-missing values on living arrangements [denominator]	**14,889**	**14,889**
Percent of clients with stable housing	**98.7%**	**99.1%**

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**11,802**
Number of CY 2010 discharges submitted:	**18,174**
Number of CY 2010 discharges linked to an admission:	**17,932**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**17,377**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**14,889**
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]	

Form T3

Form T3 was pre-populated with the following Data Source: Discharges in CY 2010

CRIMINAL JUSTICE INVOLVEMENT - NO ARRESTS (From Admission to Discharge)

Short-term Residential(SR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with no arrests [numerator]	**9,623**	**10,606**
Total number of clients with non-missing values on arrests [denominator]	**11,341**	**11,341**
Percent of clients with no arrests	**84.9%**	**93.5%**

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**9,679**
Number of CY 2010 discharges submitted:	**12,325**
Number of CY 2010 discharges linked to an admission:	**12,204**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**12,021**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**11,341**
Source:SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Long-term Residential(LR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with no arrests [numerator]		
Total number of clients with non-missing values on arrests [denominator]		
Percent of clients with no arrests		

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**0**
Number of CY 2010 discharges submitted:	**0**
Number of CY 2010 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**

Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**0**
Source:SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Intensive Outpatient (IO)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with no arrests [numerator]	**17,852**	**18,058**
Total number of clients with non-missing values on arrests [denominator]	**19,420**	**19,420**
Percent of clients with no arrests	**91.9%**	**93.0%**

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**18,640**
Number of CY 2010 discharges submitted:	**23,684**
Number of CY 2010 discharges linked to an admission:	**23,274**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**22,938**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**19,420**
Source:SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Outpatient (OP)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with no arrests [numerator]	**15,079**	**15,019**
Total number of clients with non-missing values on arrests [denominator]	**15,638**	**15,638**
Percent of clients with no arrests	**96.4%**	**96.0%**

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**11,802**
Number of CY 2010 discharges submitted:	**18,173**
Number of CY 2010 discharges linked to an admission:	**17,931**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**17,755**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**15,638**

Source:SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file
[Records received through 12/7/2011]

Form T4

Form T4 was pre-populated with the following Data Source: Discharges in CY 2010

ALCOHOL ABSTINENCE

Short-term Residential(SR)		
A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol [numerator]	**6,786**	**10,022**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**11,524**	**11,524**
Percent of clients abstinent from alcohol	**58.9%**	**87.0%**
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		**3,331**
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**4,738**	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		**70.3%**
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		**6,691**
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**6,786**	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		**98.6%**

Notes (for this level of care):

Number of CY 2010 admissions submitted:	**9,679**
Number of CY 2010 discharges submitted:	**12,325**
Number of CY 2010 discharges linked to an admission:	**12,204**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**12,021**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**11,524**
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Long-term Residential(LR)		
A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from alcohol		
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		

Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	0
Number of CY 2010 discharges submitted:	0
Number of CY 2010 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	0
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	0
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol [numerator]	16,474	19,321
All clients with non-missing values on at least one substance/frequency of use [denominator]	21,095	21,095
Percent of clients abstinent from alcohol	78.1%	91.6%

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		3,499
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,621	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		75.7%

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)

Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		15,822
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	16,474	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		96.0%

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	18,640
Number of CY 2010 discharges submitted:	23,684
Number of CY 2010 discharges linked to an admission:	23,274
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	22,938
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	21,095
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Outpatient (OP)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol [numerator]	13,563	15,892
All clients with non-missing values on at least one substance/frequency of use [denominator]	16,845	16,845
Percent of clients abstinent from alcohol	80.5%	94.3%

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		2,832
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,282	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		86.3%

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		13,060
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	13,563	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		96.3%

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	11,802
Number of CY 2010 discharges submitted:	18,173
Number of CY 2010 discharges linked to an admission:	17,931
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	17,755
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	16,845
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Form T5

Form T5 was pre-populated with the following Data Source: Discharges in CY 2010

DRUG ABSTINENCE

Short-term Residential(SR)		
A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs [numerator]	**3,502**	**8,880**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**11,524**	**11,524**
Percent of clients abstinent from drugs	**30.4%**	**77.1%**
B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**5,505**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**8,022**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**68.6%**
C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**3,375**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**3,502**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**96.4%**

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**9,679**
Number of CY 2010 discharges submitted:	**12,325**
Number of CY 2010 discharges linked to an admission:	**12,204**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**12,021**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**11,524**
Source:SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from drugs		

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		

Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	0
Number of CY 2010 discharges submitted:	0
Number of CY 2010 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	0
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	0
Source:SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs [numerator]	13,811	17,672
All clients with non-missing values on at least one substance/frequency of use [denominator]	21,095	21,095
Percent of clients abstinent from drugs	65.5%	83.8%

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		5,000
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	7,284	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		68.6%

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		12,672
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	13,811	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		91.8%

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	18,640
Number of CY 2010 discharges submitted:	23,684
Number of CY 2010 discharges linked to an admission:	23,274
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	22,938
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	21,095
Source:SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs [numerator]	14,887	15,644
All clients with non-missing values on at least one substance/frequency of use [denominator]	16,845	16,845
Percent of clients abstinent from drugs	88.4%	92.9%

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		1,485

Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,958	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		75.8%

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		14,159
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	14,887	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		95.1%

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	11,802
Number of CY 2010 discharges submitted:	18,173
Number of CY 2010 discharges linked to an admission:	17,931
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	17,755
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	16,845
Source:SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 12/7/2011]	

Form T6

Form T6 was pre-populated with the following Data Source: Discharges in CY 2010

SOCIAL SUPPORT OF RECOVERY - SELF-HELP ATTENDANCE (From Admission to Discharge)

Short-term Residential(SR)		
Social Support of Recovery – Clients Attending in Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients attending self-help programs [numerator]	**816**	**2,287**
Number of clients attending self-help programs [numerator]	**5,295**	**5,295**
Percent of clients attending self-help programs	**15.4%**	**43.2%**
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	**27.8%**	

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**9,679**
Number of CY 2010 discharges submitted:	**12,325**
Number of CY 2010 discharges linked to an admission:	**12,204**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**12,021**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**5,295**
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]	

Long-term Residential(LR)		
Social Support of Recovery – Clients Attending in Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients attending self-help programs [numerator]		
Number of clients attending self-help programs [numerator]		
Percent of clients attending self-help programs		
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]		

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**0**
Number of CY 2010 discharges submitted:	**0**
Number of CY 2010 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**0**
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]	

Intensive Outpatient (IO)		
Social Support of Recovery – Clients Attending in Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients attending self-help programs [numerator]	**2,025**	**2,933**
Number of clients attending self-help programs [numerator]	**9,154**	**9,154**
Percent of clients attending self-help programs	**22.1%**	**32.0%**
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	**9.9%**	

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**18,640**
Number of CY 2010 discharges submitted:	**23,686**
Number of CY 2010 discharges linked to an admission:	**23,275**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**22,939**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**9,154**
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]	

Outpatient (OP)		
Social Support of Recovery – Clients Attending in Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients attending self-help programs [numerator]	**1,624**	**2,044**
Number of clients attending self-help programs [numerator]	**7,161**	**7,161**
Percent of clients attending self-help programs	**22.7%**	**28.5%**
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	**5.8%**	

Notes (for this level of care):	
Number of CY 2010 admissions submitted:	**11,802**
Number of CY 2010 discharges submitted:	**18,174**
Number of CY 2010 discharges linked to an admission:	**17,932**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**17,756**
Number of CY 2010 linked discharges eligible for this calculation (non-missing values):	**7,161**
Source: SAMHSA/CBHSQ TEDS CY 2010 admissions file and CY 2010 linked discharge file [Records received through 5/4/2011]	

Form T7

Length of Stay (in Days) of All Discharges

Most recent year for which data are available	From: 1/1/2010 To: 12/31/2010

Length of Stay			
Level of Care	**Average**	**Median**	**Interquartile Range**
Detoxification (24-Hour Care)			
1. Hospital Inpatient			
2. Free-standing Residential	2.73	3	1
Rehabilitation / Residential			
3. Hospital Inpatient			
4. Short-term (up to 30 days)	23.21	21	14
5. Long-term (over 30 days)			
Ambulatory (Outpatient)			
6. Outpatient	82.47	66	67
7. Intensive Outpatient	71.33	57	85
8. Detoxification			
Opioid Replacement Therapy (ORT)			
9. Opioid Replacement therapy	504.34	246	503

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Agency's capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

What actions does the State take as a result of analyzing performance management data?

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

Do workforce development plans address NOMs implementation and performance-based management practices?

Does the State require providers to supply information about the intensity or number of services received?

Treatment Performance Measures

The Department of Mental Health, Division of Alcohol and Drug Abuse (ADA), as the Single State Authority (SSA) has used data-driven decisions based on a limited number of performance measures in the past. Effective October 1, 2006 the SSA implemented a web-based information system Customer Information Management, Outcomes, and Reporting System (CIMOR). CIMOR replaced multiple legacy systems – integrating billing and client tracking. This system has been designed to capture the data elements needed for Treatment Episode Dataset / National Outcomes Measures (TEDS/NOMS) reporting at admission, at level changes, and at discharge.

Design flaws in the initial CIMOR data model, negatively impacted the data integrity of the State's outcome data. Initially, updates to the TEDS data resulted in overwriting of previously collected data. A fix was implemented in July 2007 but caused other difficulties in linking records in related tables. Work to re-design the tables began in spring 2008. The new TEDS screens and data tables went into production in May 2010.

ADA continues to use data quality reporting to notify service providers of missing or inconsistent data. In FY 2009, ADA developed a process to identify duplicate ids assigned to the same consumer. When identified, these ids are forwarded to the help desk staff for consolidation. During spring 2009, ADA began requiring verified social security numbers which has helped reduce the number of duplicate ids assigned to the same consumer. ADA continues to maintain and distribute the ADA Data Guidance Document which provides definitions and instructions for much of its data including the TEDS/NOMS data: http://dmh.mo.gov/docs/ada/cimorguidance.pdf.

ADA has deployed on-demand, provider-level NOMS report to CIMOR. This report allows providers to view their agencies NOMS data and comparable statewide data by program. With the new TEDS screens, ADA is also collecting data on babies born drug-free for female consumers and grade point average data for adolescent programs. This data is used by ADA as outcomes measures for budget justification. In FY 2011, ADA began sending quarterly summary reports of outcome data to ADA provider directors and agency CIMOR liaisons.

With its Access to Recovery III (ATR III) program, ADA research staff run a set of reports monitoring number served including separate breakouts for target populations (military population, Department of Corrections re-entry population, and treatment court participants), amounts of vouchered services issued and redeemed, GPRA follow-up collection rates, and average per consumer costs. These measures are tracked by site, provider, type of voucher (recovery support vs. clinical treatment), recovery oriented system of care (Southeast, Southwest, and West Central/Kansas City), and program wide. Reports are provided to ATR III management staff on a weekly basis. An additional measure "length of engagement" will be added to the reports at the beginning of FY 2012.

ADA requires providers to supply information about the intensity and number of services provided to consumers via the CIMOR system. Service data are being used to determine retention, transition to other levels of care, individualization of services, and utilization of medication assisted treatment and motivational interviewing. During FY 2012, ADA will continue to develop and implement process measure reports based on service data. These reports will address various issues including, but not limited to, data collection and reporting efforts; treatment planning, engagement, and retention; and business practices. The reports will be used in monitoring efforts and to target technical assistance.

In 2006, ADA, in conjunction with the Center for Substance Abuse Treatment (CSAT), provided training on the importance of the national outcome measures under the professional development track at the Spring Training Institute. With the implementation of CIMOR in fall 2006, ADA conducted face-to-face provider trainings across the state during 2006 and 2007. In fall 2009, ADA began quarterly webinars for providers covering various CIMOR functionalities, billing procedures, and emerging issues. In March 2010, ADA research staff conducted a training webinar for ADA service providers on the redesigned TEDS screens and data quality issues. On an as needed basis, CIMOR alerts are sent to executive directors and CIMOR liaisons at provider agencies. These alerts provide information on policies and procedures that impact CIMOR data collection and reporting. Updates to the ADA Guidance Document are communicated to providers via CIMOR alerts as well as posting the updated version to the ADA website.

ADA continues to seek outside data linkages to be used to assess data quality in ADA's information infrastructure as well as to expand its information base. During 2009, ADA established linkage with the Department of Revenue driver's license records containing DWI administrative data. This data was used to assess the data quality and referral process for ADA's traffic offender program. Also, ADA has established linkage with the Department of Corrections (DOC) to monitor prison recidivism for those parolees and probationers who are receiving substance abuse treatment.

Treatment Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Form P1
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: 30-Day Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.	Ages 18+ - CY 2009	55	
		Ages 12–17 - CY 2009	12	
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having smoked a cigarette during the past 30 days.	Ages 12–17 - CY 2009	11	
		Ages 18+ - CY 2009	27	
3. 30-day Use of Other Tobacco Products	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).	Ages 18+ - CY 2009	11	
		Ages 12–17 - CY 2009	7	
4. 30-day Use of Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12–17 - CY 2009	4	
		Ages 18+ - CY 2009	6	
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 12–17 - CY 2009	3	
		Ages 18+ - CY 2009	2	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form P2
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 18+ - CY 2009	80	
		Ages 12–17 - CY 2009	77	
2. Perception of Risk From Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - CY 2009	92	
		Ages 18+ - CY 2009	95	
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 18+ - CY 2009	76	
		Ages 12–17 - CY 2009	82	

((s)) Suppressed due to insufficient or non-comparable data

Form P3
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Age of First Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of alcohol.	Ages 12–17 - CY 2009	13.20	
		Ages 18+ - CY 2009	16.90	
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.	Ages 18+ - CY 2009	15.40	
		Ages 12–17 - CY 2009	12.90	
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.	Ages 18+ - CY 2009	19.30	
		Ages 12–17 - CY 2009	13.40	
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of marijuana or hashish.	Ages 12–17 - CY 2009	13.80	
		Ages 18+ - CY 2009	18	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of other illegal drugs.	Ages 18+ - CY 2009	19.80	
		Ages 12–17 - CY 2009	13	

((s)) Suppressed due to insufficient or non-comparable data

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - CY 2009	90.30	
2. Perception of Peer Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.	Ages 12–17 - CY 2009	88.20	
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - CY 2009	84.70	
4. Disapproval of Using Marijuana Regularly	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - CY 2009	85.20	
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - CY 2009	85.30	

((s)) Suppressed due to insufficient or non-comparable data

Form P5
NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference] **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.	Ages 18+ - CY 2009	39	
		Ages 15–17 - CY 2009	((s))	

((s)) Suppressed due to insufficient or non-comparable data

Form P7
NOMs Domain: Employment/Education
Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	**Source:**National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.	CY 2009	95.50	

((s)) Suppressed due to insufficient or non-comparable data

Form P8
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.	CY 2009	37.90	

((s)) Suppressed due to insufficient or non-comparable data

Form P9
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol- and Drug-Related Arrests

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	CY 2009	189	

((s)) Suppressed due to insufficient or non-comparable data

Form P10
NOMs Domain: Social Connectedness
Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Youth)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from **[DATEFILL]** through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.	Ages 12–17 - CY 2009	56.40	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12– 17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.	Ages 18+ - CY 2009	93.80	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11
NOMs Domain: Retention
Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" **Outcome Reported:** Percent reporting having been exposed to prevention message.	Ages 12–17 - CY 2009	88.10	

((s)) Suppressed due to insufficient or non-comparable data

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

P-Forms 12a- P-15 – Reporting Period

Reporting Period - Start and End Dates for Information Reported on Forms P12A, P12B, P13, P14 and P15

Forms	A. Reporting Period Start Date	B. Reporting Period End Date
Form P12a Individual-Based Programs and Strategies —Number of Persons Served by Age, Gender, Race, and Ethnicity	10/1/2008	9/30/2009
Form P12b Population-Based Programs and Strategies —Number of Persons Served by Age, Gender, Race, and Ethnicity	10/1/2008	9/30/2009
Form P13 (Optional) Number of Persons Served by Type of Intervention	10/1/2008	9/30/2009
Form P14 Number of Evidence-Based Programs and Strategies by Type of Intervention	10/1/2008	9/30/2009
Form P15 FY 2009 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies	10/1/2008	9/30/2009

Form P12a
Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

Missouri used the MDS and manual process data collection systems.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.

Missouri collects and records a participant's race through the MDS system and manual collection process. Participants who were more than one race were reported either under a single race or "race not known or other" - the state does not use more than one race category.

Category	Description	Total Served
A. Age	1. 0-4	638
	2. 5-11	19792
	3. 12-14	16839
	4. 15-17	14812
	5. 18-20	3463
	6. 21-24	3558
	7.25-44	23049
	8. 45-64	14665
	9. 65 And Over	2244
	10. Age Not Known	166389
B. Gender	Male	45734
	Female	53326
	Gender Unknown	166389
C. Race	White	80154
	Black or African American	18073
	Native Hawaiian/Other Pacific Islander	96
	Asian	576
	American indian/Alaska Native	220
	Race Not Known or Other (not OMB required)	166330
D. Ethnicity	Hispanic or Latino	3468
	Not Hispanic or Latino	95592
	Ethnicity Unknown	166389

Form 12b
Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Description	Total Served
A. Age	1. 0-4	
	2. 5-11	
	3. 12-14	
	4. 15-17	
	5. 18-20	
	6. 21-24	
	7.25-44	
	8. 45-64	
	9. 65 And Over	19335129
	10. Age Not Known	
B. Gender	Male	
	Female	
	Gender Unknown	19335129
C. Race	White	
	Black or African American	
	Native Hawaiian/Other Pacific Islander	
	Asian	
	American indian/Alaska Native	
	More Than One Race (not OMB required)	
	Race Not Known or Other (not OMB required)	19335129
D. Ethnicity	Hispanic or Latino	
	Not Hispanic or Latino	
	Ethnicity Unknown	19335129

Numbers are based on media programs and are duplicated counts.

Form P13 (Optional)
Number of Persons Served by Type of Intervention

Form P14
Number of Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention
NOMs Domain: Evidence-Based Programs and Strategies
Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
    - Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
    - Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
    - Guideline 3: The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
    - Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.
Missouri utilizes the Strategic Prevention Framework model to implement the four guidelines. The process includes: assessment of the community needs and readiness; capacity building to mobilize and address the needs of the community; development of a prevention plan to identify the activities, programs, and strategies necessary to address the needs; implementation of the prevention plan; and, evaluation of the results to achieve sustainability and cultural competency. Missouri identifies appropriate strategies based on validated research, empirical evidence of effectiveness, and the use of local, state, and federal key community prevention leaders such as National Prevention Network, Southwest Regional Expert Team, and SAMHSA's Center for Substance Abuse Prevention. The Division of Alcohol and Drug Abuse ultimately determines whether or not a chosen intervention falls under the third guideline.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?
Missouri collects data on the number of programs and strategies through a combined electronic and manual collection process utilizing monthly progress and fidelity reporting forms.

Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	320	336	656	104	0	760
2. Total number of Programs and Strategies Funded	320	336	656	104	0	760
3. Percent of Evidence-Based Programs and Strategies	100.00%	100.00%	100.00%	100.00%	NaN	100.00%

Form P15 - FY 2009 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies

IOM Categories	FY 2009 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2009 Total SAPT Block Grant $Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct	320	$ 3055767
2. Universal Indirect	336	$ 806672
3. Selective	104	$ 2019163
4. Indicated	0	$ 0
5. Totals	760	$5,881,602.00

Note: See definitions for types of interventions in the instructions for P-14 (Universal Direct, Universal Indirect, Selective, and Indicated)

Prevention Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

Prevention Attachment D

FFY 2009 (Optional Worksheet for Form P-15)–Total Number of Evidence-based Programs/Strategies and the Total FFY 2009 SAPT Block Grant Dollars Spent on Substance Abuse Prevention Worksheet . Note: Total EBPs and Total dollars spent on EBPs may be transferred to Form P-15.

Note: The Sub-totals for each IOM category and the Total FFY 2009 SAPT Block Grant Dollars spent on Evidence-based programs/strategies may be transferred to Form P-15.

See: The instructions for Form P-14 for the Definition, Criteria and Guidance for identifying and selecting Evidence-Based Programs and Strategies.

Form P15 Table 1: Program/Strategy Detail for Computing the Total Number of Evidence-based Programs and Strategies, and for Reporting Total FFY 2009 SAPT Block Grant Funds Spent on Evidence-Based Programs and Strategies.

1	2	3	4
FFY 2009 Program/Strategy Name Universal Direct	**FFY 2009 Total Number of Evidence-based Programs and Strategies by Intervention**	**FFY 2009 Total Costs of Evidence based Programs and Strategies for each IOM Category**	**FFY 2009 Total SAPT Block Grant Funds Spent on Evidence-Based Programs/Strategies**
1.			
2.			
3.			
4.			
Subtotal			
Universal Indirect Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Selective Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Indicated Programs and Strategies			

1.			
2.			
3.			
4.			
Subtotal			
Total Number of (EBPs)/Strategies and cost of these EBPs/Strategies	#	$	
Total FFY 2009 SAPT Block Grant Dollars $ Spent on Evidence-Based Programs and Strategies			$

Description of Supplemental Data

States may also wish to provide additional data related to the NOMs. An approved substitution is not required to provide this supplemental data. The data can be included in the Block Grant appendix. When describing the supplemental data, States should provide any relevant Web addresses (URLs) that provide links to specific State data sources. Provide a brief summary of the supplemental data included in the appendix:

This narrative response not included because it does not exist or has not yet been submitted.

Attachment A, Goal 2: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 (http://www.healthypeople.gov/) objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

(•) Yes ( ) No ( ) Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

( ) Yes (•) No ( ) Unknown

3. Does your State Alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT Block Grant	Other State Funds	Drug Free Schools
( ) Yes	( ) Yes	( ) Yes
(•) No	(•) No	(•) No
( ) Unknown	( ) Unknown	( ) Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

( ) Yes (•) No ( ) Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau? (•) Yes ( ) No ( ) Unknown

Dissemination of materials? (•) Yes ( ) No ( ) Unknown

Media campaigns? (•) Yes ( ) No ( ) Unknown

Product pricing strategies? (•) Yes ( ) No ( ) Unknown

Policy to limit access? (•) Yes ( ) No ( ) Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxication? (HP 26-24)

(•) Yes ( ) No ( ) Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

	Yes	No	Unknown
Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers:	○	◉	○
New product pricing:	○	◉	○
New taxes on alcoholic beverages:	○	◉	○
New laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors:	○	◉	○
Parental responsibility laws for a child's possession and use of alcoholic beverages:	○	◉	○

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

◉ Yes ○ No ○ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	○	○	◉	○
Alcohol	○	○	◉	○
Marijuana	○	○	◉	○

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older?	0.08
Motor vehicle drivers under age 21?	0.02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention? (HP 26-23)

Communities: 167

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences? (HP 26-11 and 26-16)

○ Yes ◉ No ○ Unknown

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please combine them together in One Word file (or Excel, or other types) and attach here.

This narrative response not included because it does not exist or has not yet been submitted.